STATE TITLE V BLOCK GRANT NARRATIVE
STATE: VA
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Copies of signed assurances and certifications for Virginia are maintained on file in the Office of Family Health Services, Virginia Department of Health. Copies are available by contacting the Title V Director, Office of Family Health Services, 109 Governor Street, 7th Floor, Richmond, VA 23219.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

In Virginia, opportunity for public input into the MCH planning process is ongoing, utilizing the variety of stakeholders and linkages described elsewhere in the application. However, during the past year, Virginia has focused specific efforts on obtaining public input for the five-year needs assessment and the 2006 application. A PowerPoint presentation describing Title V and the MCH services that Virginia provides was developed and placed on the Office of Family Health Services web page (www.vahealth.org) along with web-based surveys that solicited input from both individual citizens and representatives of organizations that serve Virginia's women and children. Twenty-seven key stakeholder interviews were conducted and seven regional focus groups were held to obtain the input of perinatal providers and other interested parties. In addition, five regional public hearings were held across the state. Notice of the public hearings were sent to the news media and a mass mailing was sent to over 700 organizations to promote the hearings. Dr. Donna Petersen facilitated a priority setting meeting that included both the OFHS management team and approximately eighteen external partners. The input obtained from the web surveys, the key stakeholder interviews, the public hearings and the focus groups was reviewed along with quantitative data and incorporated into the priority setting process.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

The Commonwealth of Virginia, a mid-Atlantic state, encompasses 40,767 square miles. It is bordered by five other states, Maryland, Kentucky, West Virginia, Tennessee, and North Carolina as well as the District of Columbia. The Chesapeake Bay defines the eastern coast. Virginia extends 440 miles from East to West and 200 miles from North to South. Local jurisdictions are comprised of 95 counties and 40 independent cities totaling 135 localities. The VDH has grouped these localities into 35 health districts. Three of the district offices, Arlington, Fairfax, and Richmond are independent with contractual relationships to the state system.
(See www.vdh.virginia.gov/LHD/LocalHealthDistricts.asp for a state map showing local health districts.)

Across the state, the terrain varies widely, including mountainous and coastal regions, remote rural areas and large urban centers. Geography impacts services in several areas. One area of Virginia, the Eastern Shore, is actually physically connected to the state via a toll bridge/tunnel making access to the mainland services challenging. Difficult terrain, lack of medical services and transportation issues pose barriers to health care for Virginia's families.

Virginia has a great range between its urban and rural areas. Twenty-five communities have densities of less than 50 persons per square mile. Half of Virginia communities have total populations under 20,000 persons, with 24 of those having less than 10,000 persons. More that three-fourths of the state population lives within metropolitan areas, according to the U.S. Census.

According to the 2003 Census Estimate, Virginia continues to rank as the 12th most populated state with 7,386,330 residents. This is a 4.3 percent increase from 2000. Projections for the years 2000 and 2025 show the population continuing to rise to 8,466,000 persons. A large part of this growth has occurred in Northern Virginia. Virginia has 1,817,037 residents under age 18, the 14th highest child population in the country. This number represents a 21 percent increase from 1990.

The population in Virginia is 49 percent male and 51 percent female. The median age of the population is 35.7 years. Virginia has a greater proportion of younger cohorts than seen nationally. Children and teens under the age of 20 make up approximately 27 percent of the population and women of childbearing age make up approximately 22 percent of the population. In 2003, 6.7 percent of residents of the Commonwealth were under age 5 and 20.5 percent were aged 5-19.

Minority groups in Virginia include African Americans, Asian/Pacific Islanders, Native Americans, and Hispanics. The culturally diverse populations include the following groups: Cambodian, Central American, Chinese, Ethiopian, Filipino, Korean, Loa, Russian/Ukrainian, Somalian, Sierra Leone, South American, Thai and Vietnamese (VDH, Multicultural Health Task Force Report, 1999). The state ranks as 9th largest for immigrant residents and 8th among intended residence for new arrivals. In 2000 Virginia ranked as having the 16th largest Hispanic population and the 9th largest Asian population in the country. There is a continuing trend in racial and ethnic diversity in the state. The Virginia population in 2003 was 5.3 percent Hispanic compared to 2.6 in 1990, 4.5 percent Asian compared to 2.5 in 1990, and 20.4 percent African American compared to 18.8 in 1990. Multicultural population concentrations are greatest in the eastern portions of the state, with Northern Virginia and Tidewater as home to the greatest numbers of minorities. According to the 2000 Census, 10.5 percent of Virginia's children ages 5 -- 17 speak a language other than English at home.

According to the 1990 U.S. Census, three-fourths of state residents had achieved at least a high school diploma or equivalency. The 2003 American Community Summary indicates that the percentage of high school graduates or higher had risen to 84.5 percent. Overall Virginia education data compares favorably to the nation as more adults in the Commonwealth hold bachelor's degrees or have completed higher education than over two-thirds of the country. According to data from the 2003 American Community Summary, approximately 32 percent of Virginia residents hold bachelor's degrees or higher. However, percentages of educational attainment vary greatly by race and location.

African Americans and Hispanics fared worse that the total state figure of high school graduates. According to 2000 data published by Annie E. Casey Foundation, 7.7 percent of teens ages 16-19 were high school dropouts down from 10 percent in 1990.

In 1998, the average annual unemployment fell to 2.9 percent. This was at the lowest level since unemployment data was first recorded in the 1970's. Virginia experienced economic fallout from the 2001 recession and the September 11th terrorist attacks with one result being decreased state revenues. Unemployment rose to 3.5 percent in 2001, yet the state average remained below the U.S. figure of 4.8 percent. The Virginia unemployment rate in March 2005 was 3.4 percent, which was below the unemployment rate of 3.9 in March 2004. Virginia's unemployment rate remains significantly lower than the national rate of 5.4 percent in March 2005. However, the unemployment rate differs across the state. The Northern Virginia and Harrisonburg areas had the lowest unemployment rate in March 2005 at 2.9 percent. The Danville area had the highest unemployment rate at 7.4 percent.

The 2002-03 two year average poverty rate in Virginia is below the U.S. figure of 12.3 percent. In 2002-03, 10 percent of Virginia's families were living at or below the Federal Poverty Level (FPL). According to Kids Count, the median income of Virginia families with children in 2001 was $58,700 compared to $51,100 nationally. Based on a 3-year average, 2001-03, Virginia ranks 13th lowest statewide poverty rate. Poverty varies significantly by locality, and by family structure. Four cities, Norfolk, Richmond, Virginia Beach, and Newport News and one county, Fairfax, account for approximately 30 percent of children in poverty.

The increase in the number of children being raised in single parent households impacts the poverty experienced by Virginia children. The 2000 Census shows a continuing increase in the number of female-headed households with children in Virginia. In 2000, female-headed households with children under eighteen years old increased from 6.0 percent of all households in 1990 to 6.9 percent in 2000. According to the Annie E. Casey Foundation, 27 percent of children in Virginia lived in a single parent family and approximately 30 percent of female-headed households with children under 18 years of age were below the poverty level in 1999. According to KIDS COUNT data, in 2001 only 31 percent of the families headed by mothers received child support or alimony. The lack of consistent child support and other support services such as reasonably priced child care remain factors that impact the many single parent families' ability to move beyond the poverty level.

Family poverty and community resources impact the ability to obtain health care. In 2004, the Virginia Health Care Insurance and Access Survey, a telephone interview survey of over 4,000 representative households in the state was completed. The survey showed that much like the U.S. as a whole, the Commonwealth's low-income population has one of the highest rates of uninsurance. The proportion of Virginia families without health insurance living at or below 150 percent of the FPL is close to or exceeds 20 percent. Rates of insurance varied from 6.3 percent for those who were uninsured all year to 11.5 percent for those uninsured at some point during 2004. Over 11 percent of adults aged 19 to 64 lacked health insurance compared to just over 6 percent of all children 18 years and younger. Young adults aged 19 to 24 had the highest rate of uninsurance. Increases in Medicaid and FAMIS (SCHIP) enrollment since 2001 have helped to lower uninsurance rates of children and pregnant women, while higher rates of unemployment and an influx of immigrants have led to an increase in the uninsured adult population. According to this study, African Americans and Hispanics had significantly higher rates of uninsurance (11.1 percent and 27.4 percent, respectively) compared to whites. Virginians with lower education and those who had never married, were living with a partner, divorced or were separated had higher rates of uninsurance.

Health Status Indicators

Specific health status indicators highlight some of the challenges that Virginia faces. Unintentional injuries took the lives of 2,559 Virginians in 2003, making this the fifth leading cause of death. Motor vehicle crashes accounted for approximately four out of every ten of these fatalities. Although there is a continuing decline in child deaths, the leading cause of death for Virginia children is injury. Violent

and abusive behavior has been increasingly recognized as an important public health issue. In 2003, 450 people were homicide victims in Virginia (down from 491 in 2001). Of the 450 homicides, the majority died by firearms and explosives. Approximately 18 percent of all the deaths in 15-19 year-olds were classified as homicides in 2003. Homicide disproportionately affects the young African American male. During the next year the Center for Injury and Violence Prevention (CIVP) will continue their youth violence prevention program and will work with the Department of Education to address the youth violence issue. Forty-six youth ages 10-19 died from self-inflicted injuries in 2003. The CIVP will continue their suicide prevention activities during FY 06.

The racial disparity in a number of health status indicators also presents significant challenges. For example, the infant mortality rate is often used as a state health status indicator. In 2003, the rate was 7.6 per 1,000 live births. However, there continues to be a large disparity between the rates for white and for African American infants. In 2003, the rate for white infants was 6.1/1,000 as compared to 13.9/1,000 for African American infants. The infant mortality rates vary geographically with the highest rates in Chesapeake, Hampton, Portsmouth, Richmond and Roanoke districts and in the Peninsula and Southside health districts.

Of Virginia women having a live birth in 2003, 84.8 percent received first trimester prenatal care. During the same period, approximately 3.8 percent of women began prenatal care in their 3rd trimester or received no prenatal care throughout their pregnancy. There continues to be differences based on race and ethnicity. With African Americans and Hispanics less likely to have early prenatal care. The gap in early prenatal care between white mothers and African American mothers and other races in Virginia has not significantly changed from 1995 through 2003. Lower utilization by Hispanic women also reflects racial and ethnic disparities that may be magnified for immigrants who may fear contact with the medical system, encounter language barriers, or have a lack of resources and knowledge to obtain care. The Immigration and Naturalization Service estimates that the number of undocumented aliens in Virginia in 2000 was 103,000, which is an increase of approximately 87 percent from 1996 to 2000. These individuals do not have access to Medicaid or FAMIS except for emergencies. Prenatal care may not be available to them potentially placing them at greater risk for a poor birth outcome.

Low birth weight is an indicator of limited access to health care and a major predictor of infant mortality. In 2003, 8.2 percent of all live births were low birth-weight infants. Of these, the percentage of low weight births for African Americans was almost double that for whites. There has been very little change in this statistic.

Pregnancy rates for teens decreased over the past five years from 34.1 per 1000 females in 1998 to 27.4 in 2003. However, the black teen pregnancy rate remained more than double that in white teens. Teen pregnancy is a critical public health issue that affects the health, educational, social, and economic future of the family. Some areas of the state had rates more than twice this level.

Access to Health Care

Like many other states, Virginia is experiencing what many people have referred to as a crisis in access to obstetrical care. The effects have been felt most in rural areas, but suburban and urban communities are also experiencing the effects. Several small community hospitals no longer provide obstetrical care and some obstetricians have stopped providing coverage for family practice physicians who have been delivering babies or have stopped providing supervision of certified nurse midwives. Some OB/GYNs have limited their practice to gynecology due to the prohibitive cost of malpractice insurance premiums. This has resulted in women having to travel further to the hospital or delivering in the emergency rooms or perhaps having inadequate prenatal care.

In March 2004, Governor Warner issued Executive Directive 2 establishing a work group to develop recommendations for improving accessibility of obstetrical care in Virginia's rural areas. The General Assembly adopted budget language to direct a similar study by the Secretary of Health and Human Resources to make recommendations for improving access to obstetrical care for the entire state. A

workgroup consisting of General Assembly members and individuals and organizations representing rural, suburban and urban communities and interests was established. The work group received feedback from stakeholders and from the public through town hall meetings around the state, a statewide videoconference at 25 locations, and through a public e-mail address. Comments were received from more than a 1,000 Virginians.

Based on the July 1, 2004 Interim report, the Governor provided emergency authority and funding, to increase the Medicaid payment rates for outpatient obstetrical and gynecological services by 34 percent, effective on September 1, 2004. The final report, released in October 2004, includes twenty-seven recommendations in six policy areas including eligibility for services, reimbursement levels, medical malpractice, license/scope of practice, birth injury, and improving access to care. Future reports on the implementation of these recommendations will be made to the Governor and the General Assembly every two years. The full report is available at the following Web site: http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD522004/$file/HD52.pdf

The 1998 Session of the Virginia General Assembly included a budget amendment for FY 99-00 that provided for the implementation of a health insurance plan for low-income children. This insurance program was designed to assist working families with uninsured children and addressed the federal legislation establishing the State Child Health Insurance Program (SCHIP) under the new Title XXI of the Social Security Act. Under federal law, each state had the option to expand Medicaid, create their own children's health insurance program targeting low-income children or implement a combination of the two.

The plan that Virginia adopted in 1998 created the Children's Medical Security Insurance Plan (CMSIP). This program was designed for uninsured children who have not had health insurance for the past 12 months and who are not eligible for Medicaid or the state employee health insurance plan. This was not an expansion of Medicaid under Title XIX of the Social Security Act, but a program that provided Medicaid-equivalent benefit coverage for children in families up to 185 percent of the federal poverty level (FPL). The CMSIP did not require premiums and/or co-payments, but left the addition of premiums and/or co-payments as a future option. The Department of Social Services (DSS) was responsible for determining eligibility, enrolling people, and implementing a statewide outreach program. VDH supported the outreach effort by hosting "local health summits" to bring participants from schools, providers, community service organizations and local governments together. The state WIC program also mailed out over 100,000 packets containing CMSIP information and an application. Local health departments were also involved in CMSIP outreach efforts.

The Virginia Joint Commission on Health Care estimated that 72,000 children were eligible for CMSIP at its inception. However, as of June 19, 2000, only 24,680 children were enrolled and by May 2001 approximately 32,000 were enrolled. Identified barriers to enrollment included the perception that CMSIP is a "welfare" program and a complicated application process. To reduce barriers and increase enrollment, CMSIP was replaced by the Family Access to Medical Insurance Security Plan (FAMIS), as mandated by Senate bill 550 in the 2000 Virginia General Assembly. (For additional information on FAMIS visit www.famis.org). FAMIS was designed to look and act like private health insurance and to be distinct from Medicaid; each utilized different applications with different eligibility requirements and no ability to transfer applications back and forth between the programs. Medicaid applications were processed at local offices of DSS, while all FAMIS applications were processed at a central processing unit. New features of this program included a premium assistance program to enroll eligible employees into their employer's health coverage using subsidies from the state.

Substantial legislative interest was directed at FAMIS during the 2002 Session of the Virginia General Assembly. Seven bills were introduced and subsequently remanded to the Joint Commission on Health Care. The Commission studied these issues in depth. As a result of their study, an omnibus bill and budget amendment were introduced and passed in the 2003 Session of the Virginia General Assembly to incorporate changes in eligibility and benefits that established the following changes:

1) Establish a single umbrella program that incorporates both Medicaid for medically indigent children

and FAMIS retaining the program name of FAMIS with the Medicaid portion being known as FAMIS Plus.
2) Require use of a single application to determine eligibility for both Medicaid and FAMIS;
3) Include within FAMIS, coverage for the community-based mental health and mental retardation services provided for children enrolled in Medicaid.
4) Reduce the waiting period from six to four months between the time that a child was covered by private health insurance and when eligibility for FAMIS can be established; and
5) Amend the language that authorizes cost sharing within the FAMIS Plan to require a $25 per year per family enrollment fee and specify that the co-payment amounts shall not be reduced below the co-payment amounts required as of January 1, 2003.

In addition to this change, legislation was also passed that provided for 12 continuous months of coverage under FAMIS and FAMIS Plus if the family income does not exceed 200 percent of the federal poverty level at the time of enrollment. This change will create a more stable covered population of children by removing unnecessary administrative eligibility burdens on the family.

Accordingly, in August 2003, the Medicaid and Medicaid expansion SCHIP programs were re-named FAMIS Plus and the separate SCHIP program continued to be known as FAMIS. These major changes in FAMIS since September 2002 contributed to the continuous upward trend in enrollment. In particular, renaming children's Medicaid FAMIS Plus has made Medicaid and SCHIP relatively indistinguishable. Total enrollment for FAMIS and FAMIS Plus is currently 118,683, which represents 96 percent of the estimated eligibles.

In response to the new product branding, legislation was passed in 2004 that redefined the Outreach Oversight Committee to now become the Children's Health Insurance Advisory Committee. Their mission is to assess the policies, operations, and outreach efforts for FAMIS and FAMIS Plus and to evaluate enrollment, utilization of services and the health outcomes of children eligible for such programs. DMAS has also brought new leadership to its FAMIS program with an increased emphasis on services for pregnant women, mothers and children. Title V staff participate as a members of the Children's Health Insurance Advisory Committee and also work closely with these staff and offer assistance in program design and outreach.

In addition to these program changes, VDH incorporated the FAMIS/FAMIS Plus application into its Web Vision system (computer system for local health district operations). At a minimum, VDH staff are able to assist an eligible recipient with the application. If time permits, VDH can electronically complete the application and then fax it directly to the Central Eligibility Processing Unit for Medicaid eligibility determinations.

Another important legislative initiative involved the expansion of involved state agencies in the sharing of protected health information that was passed by the 2002 Virginia General Assembly as SB 264. This law was designed to clarify the authority of various state agencies to obtain and disclose protected health information in compliance with the rules promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA). The previous law covered the Departments of Health, Medical Assistance Services, Mental Health, Mental Retardation and Substance Abuse Services and Social Services. The newly defined law now includes all the agencies of the Virginia's Secretary of Health and Human Resources. Initial interagency collaboration documented over $1.2 million in cost avoidance through the sharing of health information. The initial data sharing initiative occurred between the Departments of Health and Medical Assistance Services. A recipient match was made to all reported cases of pediatric patients with elevated blood lead levels. This allowed the Department of Medical Assistance Services to notify primary care providers of the results and subsequently follow the patients to ensure that proper monitoring and intervention had taken place. Subsequent collaborative projects involved the sharing of eligibility information and the sharing of foster child enrollment for immediate case assessment and intervention services. As the final HIPAA Security Rule has been promulgated and security audits are being completed, more data sharing projects will be developed. To facilitate this data sharing, a rule was issued by the General Assembly that requires the agencies within the Secretariat of Health and Human Services to develop a data

inventory. This effort will allow all agencies to know what information are available and how it is stored. In addition, a secure mechanism for inter-agency data sharing has been established. The final report will be issued in early 2006.

In 1996, mandatory managed care enrollment in a contracted HMO began in selected counties in the Tidewater area of Virginia. To date, Medicaid managed care options are available in most areas of the Commonwealth with the exception of the southwestern counties of the state. All contracted managed care organizations (MCOs) are required to establish a program for high-risk maternity and infant cases, report to DMAS on the program components and outcome measures, and report quarterly on all births. As MCOs have demonstrated outcome improvements through their maternity programs, DMAS is reviewing the VDH BabyCare program. The current BabyCare program components are defined in regulation and have not been amended to reflect current practice. Therefore, the BabyCare program administered through the local health districts has become fragmented. DMAS recognizes that the central component of BabyCare, intensive nurse case management, is of value to high-risk women. They are working closely with Title V staff to build a program that maintains essential components but is not universally prescriptive to allow for offerings that meet the needs of the marketplace.

The local health districts continue to be essential participants in the MCO delivery system. All provider contracts are negotiated from central office where the OFHS managed care policy analyst plays an essential role in explaining local health district services, services provided by the Children with Special Health Care Needs program, and services provided by the Child Development Clinics. The local health districts, in addition to providing public health services to MCO enrollees, have become key partners for the Care Connection for Children network. They provide case finding services, provide local case assistance and facilitate referrals to local service organizations.

State Health Agency Strategic Priorities

House Bill 2097, passed by the 2003 General Assembly, requires that each state agency implement a state performance-based budgeting system. Since that time, an ad hoc advisory group of agency representatives designed the new planning and budgeting model that requires all state agencies to have strategic plans that are tied to their budget and use common language and format. The planning process was unveiled to agency heads by Governor Warner in December 2004. Since that time state agencies, including VDH, have developed their strategic plans and are currently developing service plans (operational plans) that are tied to the strategic plan and budgets. This significant change in state government planning and budgeting will provide for a greater understanding of how government dollars are spent and the return on investment.

As a result of this planning and budgeting process, the VDH's overall agency strategic goals include the following:
1. Provide strong leadership and operational support for Virginia's public health system
2. Prevent and control the transmission of communicable diseases.
3. Collaborate with partners in the health care system to assure access to quality health care services.
4. Promote systems, policies, and practices that facilitate improved health for all Virginians.
5. Collect, maintain and disseminate accurate, timely, and understandable public health information.
6. Respond timely to any emergency impacting public health through preparation, collaboration, education and rapid intervention.
7. Maintain an effective and efficient system for the investigation of deaths of unexplained or suspicious deaths of public interest.
8. Assure provision of clean and safe drinking water supplies.
9. Assure provision of safe food at restaurants and other places where food is served to the public.

State MCH Priorities

The Virginia Title V program staff collaborate with a number of agencies within the Virginia Secretariat

of Health and Human Services (SHHR) to identify and jointly address the needs of the MCH populations. Regular meetings with other agencies, cross-agency program development; workgroups and special taskforces assist in the identification of issues and the prioritization of Title V efforts. These agencies within the SHHR include the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Social Services, Department of Medical Assistance Services, Department of Health Professions, and others. In addition, collaborative meetings with agencies outside the SHHR include the Department of Education, the Joint Commission on Health Care, the Youth Commission. Title V program staff also collaborate with and seek input from professional organizations, consumer representatives, advocacy groups and community providers as well as internally with offices within the VDH such as the Office of Minority Health, the Office of Health Policy, and the Division of STD/AIDS within the Office of Epidemiology.

This year OFHS initiated special efforts to involve our external partners in setting the MCH priorities. The needs assessment process included the collection of qualitative data through public hearings, focus groups and key stakeholder interviews. In addition, Dr. Donna Petersen, Dean of the South Florida School of Public Health, facilitated a priority setting meeting of OFHS staff and external stakeholders. During the meeting the MCH priorities were developed based on the presentation of needs assessment data and the needs identified by participants.

The Title V needs assessment process served as an essential tool to reflect on system changes and examine the health status of Virginia's families. Although there have been improvements in some areas, there continues to be disparities based on race, income, age, insurance coverage and areas of the state. These variations continue to present challenges. During the next year, the Title V efforts will focus on developing and working closely with our partners to implement strategies to improve access to care, including dental care, prenatal care and breastfeeding support and expand the availability and quality of medical homes for children and women. The Title V program will also develop and promote provider education particularly in the areas of assessing and addressing risks and incorporating mental health into preventive health efforts. Our enhancement of data collection and dissemination efforts to promote evidence-based decision making in planning, policy, evaluation and allocation of resources will continue from previous years. In addition, the Title V program will begin to change our paradigm by focusing on women across the lifespan and not just women during pregnancy. This approach recognizes and promotes the relationship between healthy girls, healthy mothers, healthy babies and healthy older adult women and will focus chronic disease prevention efforts, including healthy weight and physical activity, on women's and children's health across the lifespan.

More detailed MCH-related health status indicators are reported in the FY 2006 Needs Assessment. Virginia's MCH priorities are listed in Section IV of this application. In addition, other emerging health trends, problems, gaps and barriers are also identified in the Needs Assessment Section.

B. AGENCY CAPACITY

The Office of Family Health Services within the Virginia Department of Health has responsibility for the development and implementation of the MCH Block Grant. The mission of Virginia's MCH efforts is to protect, promote and improve the health and well-being of women, children and adolescents, including those with special health care needs. Major goals include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring access to quality health care services, eliminating barriers and health disparities and strengthening the MCH infrastructure. The Office of Family Health Services is comprised of the divisions of Women's and Infants' Health, Child and Adolescent Health, Dental Health, WIC and Community Nutrition, Chronic Disease Prevention and Control and the Center for Injury and Violence Prevention. The director of the OFHS is Dr. David E. Suttle. He was appointed as director in July 2002.

MCH programs and services in Virginia are provided at each of the four levels of the MCH pyramid to

protect and promote the health of women and children, including those with special health care needs.

The Division of Women's and Infants' Health assesses and advocates for the health needs of infants and of women, particularly women of childbearing age. One program provides breast and cervical cancer screening, referral and follow-up to low income Virginia women. The division also provides comprehensive family planning services in local health departments (supported in part by Title X grant funds) to assist low-income women to plan and space their pregnancies. Several programs aim at reducing infant mortality and morbidity through home visiting, regional coalition activities (Regional Perinatal Councils), mentoring pregnant teens (Resource Mothers), nutrition counseling, nurse case management, fetal and infant mortality reviews (FIMR), community-based projects and public and professional education. The Virginia Healthy Start program and the Breast and Cervical Cancer Early Detection Program (BCCEDP) are administered in this division. Another state program coordinates the follow-up of newly diagnosed newborns with sickle cell disease and includes public and family education, testing and counseling regarding the disease. The division recently received a federal grant to develop a web-based curriculum on perinatal depression for health care providers. The division has recently established a position to focus on women's health.

The goal of the Division of Child and Adolescent Health is to give children, including children with special health care needs, a healthy start in life and help them maintain good health in the future. This is accomplished through the assessing health data, identifying resources, informing the public about child and adolescent health issues, assisting policy makers, supporting private and public health care providers, developing programs and information systems, identifying resources, providing clinical consultation and educational activities, and developing and distributing guidelines and educational materials. Programs administered in the division include the Abstinence Education Initiative, Teen Pregnancy Prevention Initiative, Child Lead Poisoning Prevention, Virginia Newborn Screening Services, Metabolic Treatment Services/PKU Management, Virginia Congenital Anomalies Reporting and Education System (birth defects registry), School Health, Adolescent Health, Child Development Clinics, Virginia Early Hearing Detection and Intervention Program, Virginia Bleeding Disorders Program, and Care Connection for Children. In addition, division staff participates on the Part C Early Intervention Agencies Committee, the Early Intervention Interagency Management Team, and the Virginia Interagency Coordinating Council.

The Division of Dental Health's primary goal is to prevent dental disease. Dental services are provided in approximately half of Virginia's localities to pre-school and school age children who meet eligibility requirements through the local health departments. Eligibility for these services may be determined by school lunch status and/or family income. Dental services are available at health department clinics or at dental trailers placed on school property. Adult care is available on a limited basis in certain localities. The Division of Dental Health also supports community fluoridation by monitoring water systems for compliance in conjunction with Virginia Department of Health Office of Drinking Water, reporting water system data to the Center's for Disease Control and Prevention Water Fluoridation Reporting System (WFRS), providing information about the benefits of water fluoridation to citizens and communities, and by providing grant funding for communities to start or upgrade fluoridation equipment.

The Division of Dental Health also supports the School Fluoride Mouthrinse Program through the MCH Block Grant and provides funding for fluoride mouthrinse supplies, training in implementing school mouthrinse programs, brochures and educational information regarding the fluoride mouthrinse program. Most recently, the division implemented the "Bright Smiles for Babies" Program to targeted children from birth to three years old at highest risk for dental decay. This program's goal is to increase early recognition of disease and prevention through training dental and non-dental health professionals on oral health education and anticipatory guidance, screening and risk assessment and fluoride varnish application. The division also administers the Dental Scholarship Program that provides funding for dental students with repayment through service in dental underserved areas or eligible state agencies that provide dental services.

The WIC and Community Nutrition Services Division administers Virginia's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The programs goal is to enable women to deliver and nurture healthy children. The program serves approximately 136,000 low- to moderate-income families through local health departments and mobile clinics. The program includes outreach and education components. The division's other programs focus on increasing physical activity, reducing obesity, especially childhood obesity, promoting breastfeeding, preventing osteoporosis and preventing birth defects by promoting awareness of the importance of folic acid.

The goal of the Chronic Disease Prevention and Control Program is to reduce the human and financial burden of chronic diseases, which are the leading causes of death in Virginia. The division's prevention and control efforts include the development of programs and policies, training and state action plans that outline goals and strategies for business, civic and governmental agencies to use to control chronic diseases such as arthritis, asthma, cancer, diabetes, or heart disease and stroke. The division focuses on promoting evidence-based interventions, monitoring the burden of chronic diseases in the state, developing partnerships with other state and local agencies, and evaluating outcomes of projects' interventions. Other division efforts include outreach to promote health for persons living with disabilities and prevention of secondary chronic diseases, and to modify risk behaviors such as tobacco use, lack of physical activity and poor nutrition, which are major contributing factors leading to chronic diseases. The division manages numerous categorical CDC grants including the CDC funded Tobacco Use Control Program (TUCP). In addition, the Virginia Cancer Registry is located within this division.

The Center for Injury and Violence Prevention's vision is that Virginia will be a place where people live, learn and play safely. To reduce the impact of injury and violence, the center engages in injury assessment, the development and promotion of prevention programs and policies, and training and community education. The center also promotes and disseminates safety devices, conducts public information campaigns and funds local prevention projects. The center works collaboratively with schools and day care centers, health, social service and mental health providers, law enforcement, fire and EMS providers, and a variety of other community groups across the Commonwealth. The center's unintentional injury programs address home safety, passenger safety, bike safety, playground safety and fire and falls prevention. The center's violence prevention programs address sexual violence prevention, suicide, youth and domestic violence prevention.

The Office of Family Health Services is responsible for addressing several federal (e.g., Title V and Title X) and state mandates for improving the health of women and children. State statues relevant to the Virginia's Title V program authority including the following:

Virginia Congenital Anomalies Reporting and Education System (Code of Virginia Section 32.1-69). Establishes a system to collect data to evaluate the possible causes of birth defects, improve the diagnosis and treatment and establish a mechanism for informing the parents and physicians regarding available resources. This program is administered by the Division of Child and Adolescent Health.

Newborn Screening (Code of Virginia Section 32.1-65). Establishes testing requirements for newborn infants for metabolic disorders. The Division of Child and Adolescent Health administers this program.

Sickle Cell Screening (Code of Virginia Section 32.1-38). Establishes screening and education and post-screening counseling for individuals with sickle cell anemia or the sickle trait. (Sickle cell screening is included in newborn screening program administered by the Division of Child and Adolescent Health. The on-going education and counseling component is administered by the Division of Women's and Infants' Health.)

Newborn Hearing Screening (Code of Virginia Section 32.1-64.1). Establishes the newborn hearing screening program (Virginia Early Hearing Detection and Intervention Program). The Division of Child and Adolescent Health administers this program.

State Plan for MCH and CSHCN (Code of Virginia Section 32.1-77). Authorizes the development and submission of state plans for maternal and child health and children with special health care needs to the federal government and authorizes the state health commissioner to administer and expend federal Title V funds.

Bleeding Disorders Program (Code of Virginia Section 32.1-89). Establishes a program for the care and treatment of persons suffering from hemophilia and other related bleeding diseases who are unable to pay for the cost of services. Also establishes the Hemophilia Advisory Committee with members appointed by the Governor. This program is administered by the Division of Child and Adolescent Health.

Prenatal Testing (Code of Virginia Section 32.1-60). Requires that physicians attending a pregnant woman to examine and test for venereal diseases.

Child Immunizations (Code of Virginia Section 32.1-46). Establishes immunization requirements for children. The Virginia Board of Health in conjunction with the Virginia Department of Education promulgates the rules and regulations regarding this requirement. The Division of Immunizations in the VDH Office of Epidemiology administers the state immunization program.

State Child Fatality Review Team (Code of Virginia Section 32.1-238.1). Establishes the State Child Fatality Review Team to review violent and unnatural child deaths, sudden child deaths occurring within the first 18 months of life and those fatalities where the cause cannot be determined with reasonable medical certainty. The VDH Chief Medical Examiner chairs the team that includes 16 members representing relevant state agencies and organizations.

Preschool Physical Examinations (Code of Virginia Section 22.1-270). Requires that students entering any public kindergarten or elementary school for the first time have a physical examination that becomes a part of the student's school health record. This record is available for review by state and/or local health department staff. Also requires that health departments in all counties and cities conduct the preschool physical examinations for medically indigent children at no cost.

Elevated Blood-lead Testing (Code of Virginia Section 32.1-46.1, 32.1-46.2). Requires that the Board of Health establish a protocol for identification of children with elevated blood-lead levels. The regulations established by the board requires blood-lead level testing at appropriate ages and frequencies, when indicated and provides for the criteria for determining low risk elevated blood-lead levels and when testing is not indicated. This program is administered in the Division of Child and Adolescent Health.

State Health Department Public Health Programs (Code of Virginia Section 32.1-2). Requires that the Board of Health and the Virginia Department of Health administer public health programs including prevention and education activities focused on women's health, including, but not limited to, osteoporosis, breast cancer, and other conditions unique to or more prevalent among women. Also requires the development and implementation of health resource plans, the collection and preservation of vital records and health statistics and the abatement of health hazards.

The Advisory Board on Child Abuse and Neglect (Code of Virginia Section 63.2-1528). Establishes a board to advise the Department of Social Services, the state Social Services Board and the Governor on matters concerning programs for the prevention and treatment of abused and neglected children and their families. The Board consists of Governor appointees as well as relevant state agency heads including the Commissioner of Health. An OFHS staff member represents the Commissioner on this board.

Children's Health Insurance Program Advisory Committee (Code of Virginia Section 32.1-351.2). Establishes a committee to assess the policies, operations, and outreach efforts for the Family Access to Medical Insurance Security (FAMIS). An OFHS staff member serves as the Virginia

Department of Health representative on this committee. In addition, the Department of Medical Assistance Services is required to enter into agreements with the Department of Education and the Department of Health to identify children who are eligible for free or reduced school lunches or WIC in order to expedite the eligibility for FAMIS.

Children with health problems or handicapping conditions (Code of Virginia Section 32.1-78). Requires the Commissioner of Health to report to the Superintended of Public Instruction or local superintendent to identify children with health problems or handicapping conditions, which may affect school work and the need for special education.

Child Restraints in Motor Vehicles (Code of Virginia Section 46.2-1097). Requires the Department of Health to operate a program to promote, purchase and distribute child restraint devices to families who are financially unable to purchase the restraint devices. The program is funded through civil penalties. The OFHS Center for Injury and Violence Prevention administers this program.

Asthma Management Plan (Code of Virginia Section 32.1-73.5 and 73.6). Requires the Department of Health to develop, maintain, and revise a written comprehensive state plan and implement programs, using funds appropriate for that purpose, for reducing the rate of asthma hospitalizations. The plan's primary emphasis is, but not limited to, children between the ages of birth and eighteen years. The OFHS Division of Chronic Disease Prevention, in conjunction with the OFHS Division of Child and Adolescent Health, is responsible for this effort.

Youth Suicide Prevention (Code of Virginia Section 32.1-73.7). The Department of Health in consultation with the Department of Education, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, along with the community services boards and the local health departments, have the lead responsibility for the youth suicide prevention program. The OFHS Center for Injury and Violence Prevention is responsible for this effort.

School Health Services (Code of Virginia Section 22.1-274). Specifies that a school board may employ school nurses, physicians, physical therapists, occupational therapists and speech therapists to provide student support services. Upon approval of the local governing body a local health department may provide personnel for health services for the school district. Staff within the OFHS Division of Child and Adolescent Health Services work closely with the Department of Education's school nursing program.

Domestic Violence Surveillance (Code of Virginia Section 32.1-283.3). The Virginia Department of Health's Chief Medical Examiner shall provide ongoing surveillance of family violence fatalities, prepare an annual report, develop protocols for local family violence fatality review teams and serve as a clearinghouse for information. The OFHS Center for Injury and Violence Prevention works closely with the Medical Examiner's Office on this effort.

Dental Loan Repayment Program (Code of Virginia Section 32.1-122.9:1). The Board of Health is required to establish a dentist loan repayment program for graduates of accredited dental schools who meet the criteria established by the Board. These criteria require that the recipient agree to perform a period of dental service in an underserved area of the Commonwealth. The OFHS's Division of Dental Health administers this program.

Comprehensive Services for At-Risk Youth and their Families (Code of Virginia Section 2.2-2648, 2.2-5001, 2.2-5007, 2.2-5205 -- 06). The State Health Commissioner serves as a member of the Executive Council that is intended to facilitate a collaborative system of services and funding that is child-centered, family focused, and community-based when addressing the strengths and needs of troubled and at-risk youth and their families.
The Comprehensive Services for At-Risk Youth and Families also includes local health department staff on the community policy and management teams, the family assessment and planning teams and a state management team with a representative from the Office of Family Health Services.

Early Intervention Services -- Part C (Code of Virginia Section 2.2-5300 -- 2.2-5308). Establishes an early intervention agencies committee to ensure the implementation of a comprehensive system for early intervention services as required in Part C of the federal Individuals with Disabilities Education Act (IDEA). An OFHS staff member represents the Health Commissioner serves on this committee. Also establishes local interagency councils that include local health department participants.

C. ORGANIZATIONAL STRUCTURE

Mark R. Warner was sworn in as Virginia's Governor in January 2002. He became the first Democratic governor in eight years. Jane Woods, a former Virginia legislator who developed expertise in health care while serving as the Vice-Chairman of the Joint Commission on Health Care and Chairman of its Long Term Care subcommittee, was named Secretary of Health and Human Resources. Governor Warner named Robert B. Stroube, M.D., M.P.H. who has served in the past as the State Health Commissioner, and more recently as the Acting State Health Commissioner following the departure of E. Anne Peterson, State Health Commissioner.

Unlike other states, Virginia does not permit the governor to hold consecutive terms and therefore a new governor will take office in January 2006. This will undoubtedly result in numerous changes in agency heads and new gubernatorial initiatives.

The Virginia Department of Health is mandated by the Code of Virginia to "administer and provide a comprehensive program of preventive, curative, restorative and environmental health services, educate the citizenry in health and environmental matters, develop and implement health resource plans, collect and preserve vital records and health statistics, assist in research, and abate hazards and nuisances to the health and environment, both emergency and otherwise, thereby improving the quality of life in the Commonwealth." In carrying out these responsibilities, VDH promulgates and enforces over 60 sets of regulations and manages over 70 federal and state grants. Organizationally VDH consists of a Central Office, 35 health districts, with numerous operational sites and hundreds of contractors. Three of the district offices, Arlington, Fairfax, and Richmond are independent with contractual relationships to the state system. See the Virginia Department of Health's Web site at http://www.vdh.virginia.gov/

Section 32.1-77 of the Code of Virginia specifically addresses VDH's authorization to prepare and submit to the U.S. Department of Health and Human Services the state Title V plan for maternal and child health services and services for children with special health care needs. The Commissioner of Health is authorized to administer the plan and expend the Title V funds.

Within the central office of VDH, the Maternal and Child Health Services Block Grant is managed by the Office of Family Health Services (OFHS). Dr. David Suttle is the OFHS director and reports directly to the Deputy Commissioner for Public Health, Dr. James Burns. Other offices under the direction of the Deputy Commissioner include the Office of Emergency Medical Services, the Office of Environmental Health Services, the Office of Drinking Water, and the Office of Epidemiology.

The administration of the Block Grant resides at the OFHS office level while divisions within the Office have specific responsibility for carrying out MCH programs. The divisions include Dental Health, Women's and Infants' Health, Chronic Disease Prevention and Control, Child and Adolescent Health, WIC and Community Nutrition and the Center for Injury and Violence Prevention. The CSHCN program resides within the Office's Division of Child and Adolescent Health. The OFHS mission and organizational placement within VDH remain the same as described in previous Maternal and Child Health Services Block Grant applications.

The Virginia State Government Organizational Chart is available at http://www.commonwealth.virginia.gov/

Virginia Department of Health's Organizational Charts for the Commissioner's Office and the Office of

Public Health Programs are available at http://www.vdh.virginia.gov/

D. OTHER MCH CAPACITY

Virginia's MCH Program, comprised of staff in the Office of Family Health Services, includes a highly skilled and diverse team of public health professionals representing a variety of disciplines. Thirty-six and a half full-time equivalent positions (FTEs) in the OFHS are funded by the MCH Block Grant. In addition, numerous district health department staff, including physicians, public health nurses, and support staff are also supported in part by Title V funds.

Senior level MCH staff in the Office of Family Health Services include the following:

David E. Suttle, M.D. is Board Certified in Pediatrics with a specialty in adolescent medicine. Dr. Suttle has served in his current capacity as Director of the Office of Family Health Services since July 2002. Previously he served in the U.S. military in direct health care administration and health policy.

Janice M. Hicks, Ph.D. has served as the Policy and Assessment Director since 1997 and as the Office of Family Health Services' Senior Policy Analyst since 1994. She has over 20 years of experience in planning, evaluation and legislative analysis. Dr. Hicks also has experience in teaching college level courses in Sociology, Research Methods, Evaluation, Social Theory, Family, and Criminology/Juvenile Delinquency. She also serves as an adjunct faculty member in the Virginia Commonwealth University's Sociology Department. The policy and assessment unit includes the grants coordinator (Robin Buskey), the State Systems Development Initiative (SSDI) Coordinator who also serves as the MCH Epidemiologist (Derek Chapman), the Behavior Risk Factor Surveillance System Coordinator (Susan Spain), the public relations coordinator (Charles Ford) and a senior health policy analyst (Kim Barnes) who continues to serve as the agency HIPAA compliance officer and the OFHS liaison to the Department of Medical Assistance Services on issues involving Medicaid and FAMIS.

Karen Day, D.D.S., M.S., M.P.H., has served in her current capacity as Director of the Division of Dental Health with the Virginia Department of Health (VDH) since 1996. Prior to this position with VDH, she served as Community Water Fluoridation Coordinator for the Division for three years and as a public health dentist for fifteen years. Dr. Day has taught graduate and undergraduate courses at Virginia Commonwealth University including biology, oral epidemiology, principals of public health and public health dentistry.

Nancy R. Bullock, R.N., M.P.H., the CSHCN Program Director, has 38 years of experience in public health in Virginia. She served as a nurse consultant, program and division director at the state level and at the local level as a public health nurse and nurse manager. She has been the director of the CSHCN Program since 1991.

Joan Corder-Mabe, R.N.C., M.S., W.H.N.P., was selected as the Director for the Division of Women's and Infants' Health in 2001. Previously she served as the perinatal nurse consultant since 1992 and the Acting Director since 1998. She is responsible for programs including the Title X Family Planning, the Virginia Healthy Start Initiative, the CDC Breast and Cervical Cancer Early Detection Program, Partners in Prevention, the Resource Mothers Program, Women's Health, the Regional Perinatal Councils, and the Comprehensive Sickle Cell Program. She and the division staff also provide consultation and technical assistance to the local health departments serving perinatal clients.

Joanne S. Boise has served as Director of the Division of Child and Adolescent Health since June 2001. Prior to joining VDH, Ms. Boise spent fifteen years in the managed care industry working locally and nationally; she has held positions in health policy, HMO operations, quality improvement, utilization management, and network management. She holds an A.A.S. in Nursing (1979), B.A. in History (1976), and M.S.P.H. in Health Policy and Administration (1986).

Donna Seward, B.S., has served in her current capacity as the Director of the Division of WIC and Community Nutrition Services (DWCNS) since April 2000. She is responsible for the management of Virginia's WIC program. From 1976 to 2000 she served as the WIC Director at the local level in Texas. Her educational background is in health care management.

Erima S. Fobbs, B.Sc, M.P.H., is the Director of the Center for Injury and Violence Prevention (CIVP). Her M.P.H. includes a concentration on Epidemiology and Health Services Administration. Prior to becoming involved in injury prevention, she worked for one year as an evaluator on an AIDS education program targeted for minority communities. Her injury prevention career began in Canada in 1988 when, as the epidemiologist on a project at the University of Alberta, she prepared the first comprehensive report on injury epidemiology in Alberta and wrote a proposal leading to the permanent establishment and funding of the Alberta Injury Prevention Center. Her employment at the Virginia Department of Health began in 1994. Since that time she has developed a statewide injury and violence prevention program and directs staff in delivering services that include a resource information center, assessment, data analysis and reporting, state and community level prevention, training and education projects. She has also taught courses on the Epidemiology and Prevention of Intentional Injury as an adjunct assistant professor at MCV/VCU Department of Preventive Medicine and Public Health.

In the fall of 2004, OFHS contracted with the Virginia Commonwealth University's School of Public Health to hire a faculty level MCH epidemiologist. Derek Chapman, Ph.D. has been hired in this jointly appointed position that is supported by SSDI funds. Dr. Chapman previously served as the Director of Research at the Tennessee Department of Health and has a number of years of experience working with MCH data. He works closely with the division level epidemiologists to establish greater access to data including the development of linked data. He also works closely with the Behavior Risk Factor Surveillance System (BRFSS) Coordinator, the Director of the Center for Health Statistics and the Office of Information Management. The joint appointment of Dr. Chapman provides an opportunity for greater collaboration between the OFHS and the School of Public Health. It is anticipated that this arrangement will have benefits for both OFHS and the University through increased opportunities for grants, student internships, technical assistance and publications.

In April 2005 Susan Kennedy Spain, M.S. was hired to serve as the BRFSS Coordinator. She has fifteen years of experience in data analysis and project management. She previously was employed by the Virginia Commonwealth University's Survey Evaluation and Research Lab (SERL). She has expertise in survey development and will be an asset to the OFHS. She will be working closely with the MCH Epidemiologist to implement a routine surveillance system so that data will be routinely collected, analyzed and made available for use in program evaluation and decision making within the office.

Family Involvement

OFHS provides a number of opportunities for family input into the MCH and CSHCN programs. A parent feedback survey is used to assess the services provided by Care Connection for Children centers, Bleeding Disorders Program, and the Child Development Clinics. Although the CSHCN Program has no parent with special needs children on staff, three Care Connection for Children centers do have contractual relationships with the coordinators for Virginia Family Voices, Parent-to-Parent, and Medical Home Plus. They provide outreach, support, mentorship and training to parents. They have assisted the Care Connection for Children centers in establishing their family-to-family support services. Two of the three centers now have contracts with families from their geographic service area to provide the support services. Parents from Family Voices and Parent-to-Parent

provided input into Virginia's state CSHCN plan to meet the Healthy People 2010 goals. Parent focus groups have provided input for various MCH related programs including the Lead Program and Abstinence. Family representatives serve on the Regional Perinatal Councils, the Hemophilia Advisory Board, the Virginia Early Hearing Detection and Intervention Advisory Committee and its Parent Subcommittee, and the Virginia Lead Task Force. OFHS staff also participate in a number of organizations with families such as the Virginia Chapter of the Hemophilia Foundation, Spina Bifida Foundation, Cystic Fibrosis Foundation, Virginia SIDS Alliance, Virginia Parents Against Lead, and the Virginia Congress of Parents and Teachers. During 2005, CSHCN staff joined with parents and professionals from other state agencies and formed the Virginia Family Support Coalition which is committeed to improving information and referral services for CSHCN and their families.

E. STATE AGENCY COORDINATION

In Virginia, state health and human services agencies are organized under the jurisdiction of the cabinet level Secretary of Health and Human Resources who is appointed by the governor. The major health and human services agencies include the Department of Health, the Department of Medical Assistance Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Social Services. The Departments of Juvenile Justice and Corrections, and the Department of Education are located under different cabinet secretaries. The Health and Human Resources Secretariat also includes a number of advisory boards that provide opportunities for coordination including the Governor's Advisory Board on Child Abuse and Neglect, the Child Day Care Council and the Governor's Substance Abuse Services Council.

There are also ongoing opportunities to work with Virginia's health education programs and universities. For example, OFHS recently contracted with the Virginia Commonwealth University's (VCU) Department of Preventive Medicine and Community Health for the services of a faculty level MCH epidemiologist to work within the OFHS. VCU serves as the contractor for Virginia's Behavior Risk Surveillance Survey (BRFSS) and also provides assistance with trainings, research and report writing and evaluations of programs such as the Teen Pregnancy Prevention Initiative and the Abstinence Education Initiative. Most recently, VCU completed a Women's Health Data Book and is currently completing a report on child hospitalizations. OFHS has also worked closely with the Center for Pediatric Research, Eastern Virginia Medical School (EVMS), in conducting surveys of perinatal providers on practice issues regarding perinatal depression, children's hospitalizations, and the development of a school health information system. Virginia Polytechnic Institute and State University (VPI&SU) also provided assistance in coalition building and program evaluation. The University of Virginia (UVA) recently provided assistance related to youth violence prevention activities.

Currently OFHS contracts with Welligent (associated with EVMS) for the maintenance of client data systems including the Virginia Infant Screening and Infant Tracking System (VISITS), a web-based integrated database system that will track screening results for four programs and services: Virginia Newborn Hearing Screening Program, Virginia Congenital Anomalies Reporting and Education System (VaCARES), Early Hearing Detection and Intervention, and Infant and Toddler Connection (Part C of the Individuals with Disabilities Education Act (IDEA). The CSHCN Program, through a contractual agreement with EVMS/Welligent, implemented the Care Connection for Children System Users Network (CCC-SUN), a web-based database system. This software application is for the network of the six Care Connections for Children centers to document their services and report them to the CSHCN Program. Contracts with the tertiary care centers for genetic consultation/services and for specialized services for children with special health care needs are also maintained.

The Department of Medical Assistance Services (DMAS) continues to bring the public and private sector together to address issues related to service delivery for mothers and children. The Managed Care Advisory Committee and its subgroup, the Managed Care Workgroup, continue to address problems with enrollment, access, and retention. The committee is comprised of representatives from the six contracted Medicaid managed care organizations, VDH Title V representatives, and the departments of Mental Health and Social Services. One of the significant accomplishments was the streamlining of eligibility determinations for pregnant woman. Through a contract with a private

processing unit, a pregnant woman can now be enrolled and assigned a treating physician within 30 days to 45 days of application. Therefore, their access to prenatal services can now be accomplished during their first trimester.

Pursuant to legislation passed during the 2004 Session of the Virginia General Assembly, DMAS has brought together the public and private sector to address insurance coverage for children. The Child Health Insurance Advisory Committee (CHIPAC) has representation from state agencies, private industries, providers and consumers. The purpose of the group is to make policy recommendations concerning children's access to and utilization of health care services. Although in its infancy, this group has the support of senior management at DMAS and also members of the Virginia General Assembly.

An interagency agreement exists between VDH and DMAS for the coordination of Titles V and XIX services. The assignments of responsibilities as stated in the agreement are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory function and mission of VDH. The agreement has been modified to include a Business Associate Agreement for the purpose of data sharing. The current data sharing projects involve the exchange of blood-lead testing results, eligibility information and decedent information. In addition to the value of improved health status in the Commonwealth, these projects save the state approximately $1.2 million annually.

The interagency agreement also includes coordination of Medicaid and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). The agreement includes mechanisms to assist eligible women and infants to obtain Medicaid coverage and WIC benefits. In addition, the Maternal Outreach Program - a cooperative agreement which expands the VDH Resource Mothers Program - supports the coordination of care and services available under Title V and Title XIX by the identification of pregnant teenagers who are eligible for Medicaid and assisting them with their eligibility applications.

DMAS directs the EPSDT Program and collaborates with the VDH and DSS on specific components of the program. VDH interagency responsibilities include, when appropriate, (1) providing consultation on developing subsystem and data collection modifications and (2) collaborating on (a) modifying the Virginia EPSDT Periodicity, (b) developing screening standards and procedure guidelines for EPSDT providers, (c) developing materials to be included in the EPSDT Supplemental Medicaid Manual and other provider notices as may be required, (d) providing EPSDT educational activities targeted to local health departments, (e) implementing strategies that will increase the number of EPSDT screenings, and (f) making available current EPSDT program information brochures and other materials that are needed to communicate information to local health department patients. A web-based EPSDT training program is currently under development and will be marketed to Medicaid providers by DMAS.

In 1987, the Department of Medical Assistance Services, with the Departments of Health and Social Services, developed a plan for care coordination and other expanded services called Baby Care. The program services include outreach and care coordination for high-risk pregnant women and infants, education, counseling on nutrition, parenting and smoking cessation and follow-up and monitoring. With the advent of Medicaid Managed Care, the participating HMOs were allowed to develop proprietary Baby Care programs that met the objectives articulated in the 1987 regulations. These programs demonstrated significant improvements in birth outcomes. As the various programs were researched by DMAS, it has become evident that new Baby Care program guidance be established. This process is currently underway with an expected roll out date in early 2006.

A Memorandum of Understanding between VDH and the Virginia Department of Social Services covers the expectations related to the use of TANF funding to support the VDH Teen Pregnancy Prevention program, the Resource Mothers Sibling program (GEMS), and the Partners in Prevention program. The Title V program staff work closely with the DSS staff to ensure that the TANF funding addresses the needs of the MCH population.

The OFHS contracts with the six regional sites that make up the Statewide Human Services Information and Referral System, administered by the Virginia Department of Social Services, for information and referral services for the MCH Helpline. The toll-free number is 1-800-230-6977. The system has been helping Virginians since 1974. This number also serves as the state number for the National Baby Line to provide information and referral for prenatal care. Data documenting maternal and child health related service calls are collected and reported to the OFHS quarterly as required by the contract. This information provides data for future needs assessments and program. Copies of the most recent contracts are on file in the OFHS.

Children with Special Health Care Needs

The Division of Child and Adolescent Health's Care Connection for Children (CCC) and the Child Development Clinic Services (CDC) programs have provider agreements with the Department of Medical Assistance Services. Copies of these agreements are on file in the Office of Family Health Services and are reviewed periodically. The CCC and CDC programs bill Medicaid for pharmacy, physician, laboratory, psychological, and hearing services. In the past, DCAH worked with DMAS to revise several state-specific reimbursement codes ("Y" and "Z" codes) used for CSHCN.

A collaborative relationship has also been established between the Care Connection for Children Program, the Social Security Administration Field Office in Virginia and the Disability Determination Services in the Virginia Department of Rehabilitative Services to enhance each program's roles and responsibilities pertaining to the SSI beneficiaries. Strategies for publicizing each program, facilitating application for benefits and services, expediting referrals, acquisition of medical and other evidence, and reciprocal training about programs available to children with disabilities are continuing.

An interagency agreement exists between VDH and the Department of Education (DOE) for the inclusion of educational consultants as members of the interdisciplinary teams in CDC and CCC centers. The consultants provide liaison services among the clinics and centers, the children's families and local education agencies serving the children. Duties include administering and interpreting developmental and/or educational evaluations; identifying learning styles, strengths, and weaknesses; recommending educational strategies and modifications; consulting with school personnel regarding modifications in school programs; monitoring and reevaluating progress of the children; and providing staff development. DOE provides the position and funding and contracts with a local school division to provide the supervision and fiscal management of the position. VDH provides the housing and secretarial support and participates in the evaluation of the educational consultants.

The Title V program has established and maintains ongoing interagency collaboration for systems building in some defined areas. The Title V program collaborates with DOE to develop and maintain guidelines for school health services for CSHCN, such as the First Aid Guide for School Emergencies (Revised 2003) and the Guidelines for Specialized Health Care Procedures (Revised 2004). VDH and the Virginia Chapter of the American Lung Association have established the Virginia Asthma Coalition to assess needs, share information, and collaborate on the use of available resources.

Other Collaborative Agreements

The Commissioner of the Department of Health serves on the Early Intervention Agencies Committee that was established in 1992 through Section 2.1-760-768 of the Code of Virginia to ensure the implementation of a comprehensive system of early intervention services for infants and toddlers. A representative from the DCAH is an active participant on the Virginia Interagency Coordinating Council (VICC) and the Part C Interagency Management Team. At the local level, professional staff from the health departments and the Child Development Clinics serve on the local interagency coordinating councils.

The Comprehensive Services Act for At-Risk Youth and Families provides a comprehensive, coordinated, family-focused, child-centered, and community-based service system for emotionally and/or behaviorally disturbed youth and their families throughout Virginia. One representative from

VDH/Title V serves on the State Executive Council and another serves on the State and Local Advisory Team (SLAT). Other representatives from the state and local health departments serve on workgroups. All local health departments and/or Child Development Clinics serve on local community policy and management teams and family assessment and planning teams.

The Title V funded programs are also coordinated with other health department programs that serve a common population group including Immunization, STD/AIDS, and Emergency Medical Services. Immunizations are provided as part of local health department services as are family planning and well-child services. Screening and treatment for STDs are provided in family planning clinics. Family planning, prenatal, and well child patients may be referred to health department dental services.

Intra-agency and interagency collaboration will continue with the above mentioned agencies and others such as, WIC, the Office of Primary Care and Rural Health, Title X -- Federal Family Planning Program, the Commission on Youth, the Virginia Commission on Health Care, the VDH Office of Health Policy, the VDH Office of Minority Health, the Virginia Primary Care Association, and the Virginia Hospital and Health Care Foundation. In addition, Title V staff will continue to support community-based organizations that have been working to improve the health of the MCH population including organizations such as the Virginia Perinatal Association, the Virginia Association of School Nurses, the Virginia Chapter of the March of Dimes and numerous single disease oriented voluntary organizations.

Title V staff will continue to represent the MCH interest on numerous interagency councils, task forces and committees such as the Governor's Office for Substance Abuse Prevention (GOSAP), the Governor's Council on Substance Abuse Services, and the Governor's Advisory Board on Child Abuse and Neglect, as well as working groups such as the PASS Initiative work group.

To facilitate the work of the Secretary of Health and Human Resources, the Title V program staff will continue to provide analysis and recommendations to the Governor on legislation before the General Assembly that will directly affect VDH programs and women's and children's health in Virginia. OFHS staff will continue to review and comment on legislation, regulations, and standards of other state agencies from a maternal and child health perspective.

Copies of all interagency agreements are maintained on file in the Office of Family Health Services and are reviewed and amended as required.

A more comprehensive list of interagency work groups, advisory groups and other collaborative relationships is attached.

F. HEALTH SYSTEMS CAPACITY INDICATORS

The health systems capacity indicators are reported annually as a measure of the ability of health systems to effectively address the needs of the MCH population. In addition, the health systems capacity indicators also include measures of the adequacy of State data systems to provide relevant policy and program relevant information and data that are essential in planning, implementing and evaluating MCH efforts. See Forms 17, 18, and 19 for specific multi-year data.

Health Systems Capacity Indicator #01: The rate of children hospitalized for asthma per 10,000 children less than 5 years of age.

Asthma is considered an ambulatory sensitive condition for which hospitalizations can be largely preventive with consistent, available ambulatory care and adherence to treatment/self-care protocols. Hospital admissions may indicate access issues such as lack of insurance or few other options for service or the presence of social issues that may influence patient/family care such as homelessness or inconsistent caregivers. In 1998 39.7 /10,000 children were hospitalized for asthma. In 2002, the

rate was 38.6/10,000 and in 2003 the rate was 43.5/10,000. The Virginia data do not appear to show a trend since the 1999 rate was 50/10,000 and the 2000 rate was 37/10,000. However, if hospitalizations for this condition had been prevented substantial saving would have resulted.

Health Systems Capacity Indicator #02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial screen.

The percent of Medicaid enrollees whose age is less than one year that received at least one initial periodic screen has decreased slightly from 80.2 percent in 2001 to 73.1 percent in 2004.

Health Systems Capacity Indicator #03: The percent of State Children's Health Insurance Program enrollees whose age is less than one year who received at least one periodic screen.

The percent of State Children's Health Insurance Program (FAMIS) enrollees whose age is less than one year that received at least one initial periodic screen has slightly increased from 54.1 percent in 2001 to 55.1 percent in 2004. Low utilization numbers may suggest few options for service or the presence of social issues that may influence patient/family care such as homelessness or inconsistent caregivers, lack of transportation, etc.

Health Systems Capacity Indicator # 04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

In Virginia approximately 86.4 percent of pregnant women had adequate prenatal care in 2003 according to the Kotelchuck Index. This percent has remained relatively stable since 1998. 2004 data are not available.

Health Systems Capacity Indicator #05: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

In 2003 the Medicaid population had a higher percent of low birth weight births and infant deaths than the non-Medicaid population. They also were less likely to begin prenatal care during the first trimester and to have adequate prenatal care according to the Kotelchuck Index.

Health Systems Capacity Indicator # 06: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants, children, and pregnant women.

The percent of poverty level for eligibility for Medicaid is up to 133 percent of the Federal Poverty Level. The eligibility for the SCHIP (FAMIS) program is up to 200 percent.

Health Systems Capacity Indicator # 07: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

In 2004, 32.8 percent of EPSDT eligible children aged 6 through 9 years have received dental services during the year. This represents a small improvement over the 28.0 percent reported in 2000. One ongoing dental health care issue is the lack of Medicaid dental providers. This may be one factor in the low percent of EPSDT eligible children receiving dental care.

Health Systems Capacity Indicator # 08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs program.

In FY 04, 2.6 percent of Virginia's SSI beneficiaries less than 16 years old received rehabilitation services from the CSHCN Program. This is less than the 2003 level of 3.3 percent. Over the last few years as the model
of care for CSHCN with physical disabilities has transitioned from the provision of direct care in clinics to intensive care coordination, a broader range of children with varying financial and diagnoses is

being served. The percent of SSI clients to total clients is 10.1 percent in the Care Connection for Children centers, 3.4 percent in the Bleeding Disorders Program, and 5.4 percent in the Child Development Clinics. All of these CSHCN programs continue to provide outreach to potentially eligible families and coordination of services for those who are eligible for SSI. These are major components of the scope of services in the contracts with the local entities managing these programs.

Health Systems Capacity Indicator # 09(A), #09(B) and #09(C): These indicators relate to the Title V agencies ability to access data including linked data systems and childhood obesity and tobacco use data.

Virginia does not participate in the Youth Risk Behavior Survey (YRBS). Some school districts however, do conduct the YRBS or a partial YRBS-type survey. This limits the MCH program's ability to obtain data on a number of youth risk behaviors including obesity and the use of tobacco products. The Youth Tobacco Survey (YTS), was conducted in 2001 and again in 2003. The 2003 survey showed a 28 percent decrease in the number of high school students and a 45 percent decrease in the number of middle school students that report that they currently smoke. The Pediatric Nutrition Surveillance System (PedNSS) is now a resource for child obesity data in Virginia. However, the Virginia WIC program data, which are available to the MCH program, does not contain a sufficient sample of child obesity data. Individual school districts are required to routinely conduct hearing and vision screenings on students within specific grade levels. Although not mandated, some schools also collect data on heights and weights. The data are not maintained or analyzed at the state level. The VDH continues to work with the Department of Education to address obesity issues including the collection of obesity data.

Hospital survey data are not available in Virginia. Virginia does routinely analyze the hospital discharge data to determine the reasons for hospitalizations as well as the related charges. Virginia does not participate in PRAMS, but is considering the use of a PRAMS-like survey of new mothers or applying for PRAMS funding in the future.

The ability to link birth certificate data with other data such as WIC eligibility, newborn screening, infant death data, Medicaid eligibility or paid claims is mixed and requires additional work. Currently, infant birth and death certificates are linked and provided to the Newborn Screening program on an on-going basis. Linkages between the birth certificates and WIC, Medicaid data do not exist or are not routinely reported. Data from the birth defects surveillance system are available electronically. As a part of the SSDI grant, the MCH Epidemiologist will be working to develop linked data during the next year.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

Virginia's Title V program continues to be challenged by changing economic, social, and political forces dramatically impacting the provision of health care. Although surveys have shown decreases in uninsured rates, rising health care costs and other market forces may slow those decreases particularly among lower income persons. Virginia's revised S-CHIP program, FAMIS, has been a major force in increasing the number of children who have insurance and access to health care. The changes in the FAMIS application process have also helped to identify and enroll more children in Medicaid, again increasing access to health care.

Managed care continues to be a major force in the health insurance area with half of all Medicaid recipients now under a managed care plan. The lack of providers has presented major problems in the Commonwealth. Like many other states, Virginia is experiencing what many people have referred to as a crisis in access to obstetrical care. The effects have been felt most in rural areas, but suburban and urban communities are also experiencing the effects. Several small community hospitals no longer provide obstetrical care and some obstetricians have stopped providing coverage for family practice physicians who have been delivering babies or have stopped providing supervision of certified nurse midwives. Some OB/GYNs have limited their practice to gynecology due to the prohibitive cost of malpractice insurance premiums. This has resulted in women having to travel further to the hospital or delivering in the emergency rooms or perhaps having inadequate prenatal care. The lack of dental providers also impacts children's access to dental care, especially for Medicaid children.

Communities continue to experience changing demographics with an influx of many new multicultural populations entering the state. Title V will prioritize efforts to address the needs of the most vulnerable populations. Market forces and recently enacted laws have forced public health, along with the Title V program, to reevaluate priorities, allocation of resources, and strategies used to achieve optimum health.

During the development of the 2006 Title V Block Grant application, the OFHS Management Team along with a number of our external partners, reviewed the Title V priorities, as well as needs assessment data that included the qualitative data from the key stakeholder interviews, focus groups, and the public hearings. The following reflects the priority areas that will be used to focus OFHS activities and resources during the coming years:

1. Exercise leadership in nurturing partnerships that promote systematic communication, coordination, shared resource allocation and education around health improvement efforts.

2. Enhance data collection and dissemination efforts to promote evidence-based decision making in planning, policy, evaluation, allocation and accountability.

3. Assess and develop strategies to address underinsurance for vulnerable populations to improve access to affordable, acceptable care.

4. Evaluate, coordinate and enhance provider education in risk assessment, documentation, intervention, treatment and referral consistent with evidence-based standards of care around health issues specific to women and children.

5. Advance a holistic continuum of care model for women's health services across the life-span toward improvements in health for women, their children and their families.

6. Expand availability, quality and utilization of medical homes for children.

7. Improve access to dental care, awareness of oral health, and application of new models in dental health services.

8. Incorporate mental health into relevant preventive health efforts in MCH; participate in efforts to promote availability and quality of mental health services; and facilitate links between the mental health and health care communities.

9. Improve access to prenatal care including appropriate genetic assessment and breastfeeding support for all women across the state.

10. Apply socio-ecologic models to promote healthy weight by encouraging appropriate nutrition and safe physical activity efforts.

In addition to the 18 National Performance Measures, Virginia has identified state level performance measures that will enable the state to monitor progress related to the state MCH priorities. The State Performance Measures include the following:

1. The percent of children and adolescents who have a specific source of ongoing primary care for coordination of their preventive and episodic health care.
2. Percent of children who are overweight or obese.
3. Percent of newborns screened for hearing loss who receive recommended follow-up services.
4. The unintentional injury hospitalization rate for children 1-14 per 100,000.
5. Percent of low-income children (ages 0-5) with dental caries.
6. The number of dental providers practicing in underserved areas.
7. The proportion of children (0-21) who receive genetic testing.
8. Percent of women reporting substance use during pregnancy.
9. Percent of women with a on-going source of primary care.

State Outcome Measure:
1. The black-white low birth weight ratio among singleton live births.

B. STATE PRIORITIES

In order to identify and prioritize the issues that are affecting the MCH population in Virginia, an assortment of data collection and analysis activities were used that included both quantitative and qualitative data. Numerous secondary datasets were obtained, such as health statistics, hospital discharge, and client level service data to investigate trends and other issues affecting the MCH population. Qualitative data came from public hearings, focus groups, key informant interviews, and an on-line survey. A CAST-5 assessment was conducted in September 2004 to identify specific strengths and weaknesses in addressing the issues affecting the MCH populations.

In the meeting facilitated by Dr. Donna Petersen, OFHS staff and external partners developed the Title V priorities. The group identified priorities based on the needs assessment data and personal knowledge of issues impacting the health of Virginia's women and children. The following are the identified unranked Title V priorities:

Priority # 1: Exercise leadership in nurturing partnerships that promote systematic communication, coordination, shared resource allocation and education around health improvement efforts.

The key stakeholders identified the need for increased and improved communication, leadership and improved planning, resource development and sharing. The key stakeholders also identified the need to increase collaborative activities to address identified community needs. An overall theme identified in the CAST-5 assessment was the need for a greater leadership role in developing stronger, collaborative intra-agency and interagency systems of care that are focused on and organized around serving similar populations. During the next year, OFHS will identify specific partnerships and develop a plan for increasing communication and coordination around specific health improvement efforts.

One of the most vulnerable populations, CSHCN, remains as a major priority, receiving a large proportion of Title V funds. Improving identification of "at-risk" populations and assuring linkages with prevention, early intervention, and family support services can only be successfully accomplished through the development and nurturing of partnerships that promote systematic communication, coordination, shared resource allocation and education around health improvement efforts. NPM # 2, NPM # 5 and NPM # 7 will be used to monitor the progress on this priority.

Priority # 2: Enhance data collection and dissemination efforts to promote evidence-based decision making in planning, policy, evaluation, allocation and accountability.

Virginia will make enhancing data collection and dissemination a priority again this year. This year's needs assessment identified gaps in data for measuring health behaviors among pregnant women and adolescents specifically. The Virginia MCH program will continue to look for opportunities to partner with other agencies to collect data on youth risk behavior and will continue to advocate for Virginia's participation in the Youth Risk Behavior Surveillance System. Virginia plans to apply for funding for the Pregnancy Risk Assessment Monitoring System (PRAMS) when it is available. Both individual and organizational respondents to the needs assessment on-line survey indicated that the health department needed to ensure that health programs are working and needed to inform and educate the public and families about health issues and prevention. The key stakeholders expressed a desire for easily accessible data and the need to be informed about what data is available. The CAST-5 assessment identified the need for better data collection.

Priority # 3: Assess and develop strategies to address underinsurance for vulnerable populations to improve access to affordable, acceptable care.

The key stakeholders indicated that there is a growing number of persons who are experiencing limited access to medical and dental care. The perinatal focus groups indicated that the greatest barrier for women receiving prenatal care was the lack of access to an affordable health care system in a timely manner. The on-line survey found that both individual and organizational representatives ranked the lack of health insurance coverage for children and women as the second major health issue. In 2004, 13 percent of Virginia women did not have health insurance. The percentage of children without health insurance in Virginia varies depending on the data source used, with a range between 7 percent and 14 percent. In addition, there is a growing concern about non-English speaking and immigrant women's and children's access to health related services, particularly linguistically and culturally appropriate services.

Additional efforts addressing this priority include referring patients to Medicaid and FAMIS and assisting CSHCN families in finding insurance (enabling services) and continuing to monitor the insurance status of the vulnerable populations (infrastructure building services). NPM # 4 will be used to specifically monitor the percent of CSHCN that have adequate insurance.

Priority # 4: Evaluate, coordinate and enhance provider education in risk assessment, documentation, intervention, treatment and referral consistent with evidence-based standards of care around health issues specific to women and children.

In 2000-2002, unintentional injuries were the leading cause of deaths for persons aged 1 to 64. Unintentional injuries accounted for 52 percent of all deaths that occurred among persons aged 15 to 19. The majority of these deaths are preventable. In 2003, 57 intimate partner homicides occurred in Virginia. Nearly four of every five victims were women and three of the victims were children under the age of 18. There is also a need for continued efforts to promote healthy behaviors to reduce morbidity and mortality. Concerns relating to injury, violence, and obesity were identified in the needs assessment. The key stakeholders identified the need for expanded prevention and education services for children relating to health issues, and the need for increased education for the prevention of risky behaviors among adolescents. The on-line survey identified obesity, domestic violence and child abuse and neglect as major health related issues. The public hearings identified the need to improve training of health professionals in screening for and identifying violence and sexual abuse.

Potential activities to address this priority include continuing population-based prevention education and provider training on the identification of violence and appropriate documentation and referral. NPM # 10 and SPM # 4 will be used to monitor progress on this priority.

Priority # 5: Advance a holistic continuum of care model for women's health services across the life-span toward improvements in health for women, their children and their families.

Stakeholders in the priority setting meeting discussed the importance of extending the concept of "medical home" to women to ensure that they have an ongoing source of care. Although the Title V focus is on children and women of childbearing age, taking a life-span holistic approach recognizes the importance of overall health and the impact that may have on pregnancy. Activities related to this priority include educating women on the importance of total health, the prevention of chronic diseases for themselves and their children, and educating providers on the importance of using preventive guidelines. Other activities include the promotion of aggressive management of chronic diseases such as diabetes during and after pregnancy, and promoting preconceptual and interconceptual health, especially as it relates to their baby's health once pregnant. SPM # 9 will be used to monitor progress on this priority.

Priority # 6: Expand availability, quality and utilization of medical homes for children.

Having a medical home has been identified as an important way to ensure that children and especially CSHCN receive the comprehensive care that they need. In the medical home concept a physician provides primary care that is easily accessible, family centered, coordinated, and culturally appropriate. In 2003, 54.5 percent of Virginia CSHCN and 75 percent of children and adolescents received coordinated, ongoing, comprehensive care within a medical home. The key stakeholders and the public hearing participants identified the need for increased access to care and the need for coordinated and culturally-appropriate care. Some activities related to this priority include collaborating with other community agencies to expand the availability of medical homes (infrastructure building services) and working with families to ensure that children are referred to a medical home (enabling services). NPM # 3 will be used to monitor the progress on this priority for CSHCN and SPM # 1 will be used to monitor the progress for children and adolescents.

Priority # 7: Improve access to dental care, awareness of oral health, and application of new models in dental health services.

In 2000, the first Surgeon General's report on oral health identified a "silent epidemic" of dental and oral diseases that burdens some population groups. Oral diseases can place a major burden on low-income and underserved individuals in terms of pain, poor self-esteem, cost of treatment, and lost productivity from missed work or school days. Dental disease and access to dental care is a chronic problem among low-income populations in Virginia. In the public hearings, the need to increase access to dental services for women and children was identified. The lack of access to dental care was also a finding from the key stakeholder interviews and was identified as the most needed but not received service for children by respondents to the on-line survey. The Division of Dental Health's approach to this includes infrastructure building services such as oral health surveillance and recruitment of public health dentists. The Division also maintains a quality assurance program for public health dentists. Population-based services include dental education, community water fluoridation, and the fluoride mouth rinse program. A number of local health departments provide clinical dental services. NPM # 9 and SPM # 5 and 6 will be used to monitor the progress related to the priority.

Priority # 8: Incorporate mental health into relevant preventive health efforts in MCH; participate in efforts to promote availability and quality of mental health services and facilitate links between the mental health and health care communities.

The public hearing participants identified the need for greater access to mental health services for women and children. The key stakeholders indicated that mental health and substance abuse

services are in short supply, especially for low-income women and children. The perinatal focus groups identified women with mental health or substance abuse problems as one of the sub-populations not receiving appropriate prenatal care. Both the individual and organizational respondents to the on-line survey identified behavioral health issues as the third highest health issue for children, and depression and mental illness as the third highest issue for women. Some of the proposed approaches to address this issue included raising public awareness of the impact of mental health on overall health and the importance of viewing mental health from a public health perspective. Another approach is for the Title V program to partner with mental health to increase health care providers skills and knowledge of screening and referral for mental health/substance use issues. SPM # 8 and NPM # 16 will be used to monitor the progress on this priority.

Priority # 9: Improve access to prenatal care including appropriate genetic assessment and breastfeeding support for all women across the state.

Overall, 85 percent of women begin prenatal care during the first trimester, however the rate varies by race and ethnicity. For example, in 2003, 71.1 percent of Hispanic women and 77.2 percent of Black women began prenatal care in the first trimester. Like many other states, Virginia is experiencing what many people have referred to as a crisis in access to obstetrical care. The effects have been felt most in rural areas. Several small community hospitals no longer provide obstetrical care and some obstetricians have stopped providing coverage for family practice physicians who have been delivering babies or have stopped providing supervision of certified nurse midwives. This has resulted in women having to travel further to the hospital or delivering their babies in emergency rooms. The key stakeholders identified access to obstetrical and other perinatal services as scarce for the generally low-income population and for rural and minority residents. The perinatal focus groups indicated that the availability of prenatal care varies from locality to locality and differs widely by demographic group and access to a payment source. The on-line survey respondents identified the lack of prenatal care as being one of the top five health issues for women. Some of the efforts will focus on educating targeted populations on the importance of prenatal care (population based services) and using lay home visitors and outreach activities to increase prenatal care (enabling services). Several National Performance Measures will be used to monitor progress in this priority area (NPMs # 11, 15, 17, 18). State Outcome Measure # 1 will also provide data on the disparity between black and white low birth weight rates.

Priority # 10: Apply socio-ecologic models to promote healthy weight by encouraging appropriate nutrition and safe physical activity efforts.

Respondents to the on-line survey conducted as a part of the Title V Needs Assessment identified obesity/overweight as the top health issue for both children and women. Over the past decade, overweight/obesity has significantly increased in children living within the Commonwealth of Virginia. According to the National Survey of Children's Health in 2003, almost one-fourth (24 percent) of Virginia's children are overweight and 15 percent are at risk for being overweight. Lack of regular physical activity, accessibility to calorie dense foods, larger portion sizes, family lifestyles and lack of interest in health and media messages contribute to the childhood overweight dilemma. In addition, many children live in areas that are not conducive to safe physical activity. This approach to the overweight issue includes population-based services such as public awareness and education as well as infrastructure level approach to monitor obesity data and policy development. SPM # 2, the percent of children who are overweight or obese, will be used to measure progress on this priority.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	62	87	103	111	
Denominator	62	87	103	111	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

National Performance Measure # 1 is the same as State Performance Measure # 14. 2002 data are currently unavailable.

Notes - 2003

Appropriate follow-up = linked to appropriate specialist
Evidence = info from PCP or specialist, oral or written

Notes - 2004

2004 data not available.

a. Last Year's Accomplishments

During FY 04, the Virginia Newborn Screening Services (VNSS) Program, supported by newborn screening testing revenue (Enterprise funds) through the Division of Consolidated Laboratories Services (DCLS) and Title V funds, screened all newborns for nine inborn errors of body chemistry: (1) phenylketonuria (PKU), (2) maple syrup urine disease, (3) homocystinuria, (4) biotinidase deficiency, (5) galactosemia, (6) congenital hypothyroidism, (7) congenital adrenal hyperplasia, and (8) hemoglobinopathies. Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD) screening was implemented on March 1, 2004 following the addition of MS/MS instrumentation by DCLS. VNSS staff (two contract nurses) followed up on approximately 21,000 abnormal results and assured that confirmed cases were referred for treatment (see Form 6 for specific screening data). Enhancements were made to the DCLS and VNSS shared database, StarLIMS, to increase the efficiency of VNSS follow-up activities.

The Virginia Genetics Program (VGP) continued to support two metabolic treatment centers for children identified through VNSS at the Departments of Medical Genetics at the University of Virginia and at Virginia Commonwealth University. Eastern Virginia Medical School was added as the state's third metabolic treatment center to provide more proximal services for the Tidewater area of the Commonwealth. Under contractual agreements, these centers provide the following services: (1) 24/7 consultation for local health care providers to facilitate early diagnosis and treatment of infants identified as having abnormal results from newborn screening; (2) laboratory services to monitor blood levels and make recommendations for modification of diet and metabolic formula; (3) patient and family education related to specific disorders and their management; (4) coordination of necessary genetic testing for families to assist them in making informed decisions; and (5) provision of data and long-term case management information to the VGP. The VGP also administered the provision of special food

products, including metabolic formulas, for the treatment of individuals with inborn errors of metabolism. The VGP is supported by Enterprise and Title V funding.

In response to a 2003 Virginia General Assembly mandate, the Joint Commission on Health Care conducted a study to explore expansion of the current newborn screening panel. This study recommended the current panel be expanded to include the the disorders consistent with, but not necessarily identical to, the uniform condition panel recommended by the HRSA-commissioned report, Newborn Screening: Toward a Uniform Screening Panel and System by the American College of Medical Genetics.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain screening of inborn errors of body chemistry -- metabolic, endocrine, and hematologic.			X	
2. Monitor all newborn screening results and conduct aggressive follow-up on all abnormal results.			X	
3. Provide PKU formulas and other food products.	X			
4. Maintain the Virginia Infant Screening and Infant Tracking System (VISITS) birth defects database.				X
5. Maintain contracts with medical specialists statewide to provide metabolic treatment and consultation.	X			
6. Prepare for the expansion of newborn screening services to start March 1, 2006.			X	
7. Provide follow-up tracking for newborns identified with sickle cell disease through VASCAP.	X			
8.				
9.				
10.				

b. Current Activities

VNSS continues to screen all infants for nine inborn errors of body chemistry and track and follow-up all abnormal results. The VGP continues to administer the provision of special food products, including formulas, for the treatment of individuals with inborn errors of metabolism and oversee contractual services through the three metabolic treatment centers.

The 2005 Virginia General Assembly session introduced four bills recommending the expansion of the current panel of newborn screening disorders. Legislation mandating newborn screening expansion in Virginia by March 2006 consistent with the HRSA commissioned report and recommendations was passed and signed into law by the Governor. Additional funds for this expansion were designated in the state budget for VDH through increases in newborn screening testing fees. Emergency regulations are under development as specified in the new law to govern the program. VNSS is working with DCLS and the Virginia Genetics Advisory subcommittee on Newborn Screening to guide implementation planning. Current VNSS activities underway related to expansion implementation include hiring additional nursing and support staff for tracking, follow-up, and administrative functions anticipated with increased volume of abnormal screenings. Staff are also developing resource materials such as fact sheets, protocols, and healthcare provider training tools. VGP/VNSS will be participating in the HRSA-sponsored Mid-Atlantic Genetic and Newborn Screening Collaborative through the New

York State Department of Health Wadsworth Laboratory.

In February 2005, the vacant Newborn Screening Nurse Senior position was filled with a permanent full time employee.

c. Plan for the Coming Year

VNSS will implement screening for an additional 17 disorders by March 1, 2006. Adding these disorders to the state-mandated panel will bring Virginia into compliance with recommendations from the HRSA commissioned report by the American College of Medical Genetics. Emergency regulations governing newborn screening in Virginia will be completed and implemented for the expansion start date. Concurrent work on making these regulations permanent will be conducted as well. Statewide training events and other training activities will occur to ready practitioners for the screening of the additional disorders.

VNSS will continue the following activities: (1) ensure screening of all infants for the mandated panel of inborn errors of body chemistry; (2) track and follow-up on all abnormal results and assure that confirmed cases are referred into treatment in a timely manner; (3) administer the provision of special food products for the treatment of individuals with inborn errors of metabolism; and (4) provide necessary education and technical assistance to providers. VNSS will continue work to enhance the follow-up and reporting functions of the StarLIMS database. These enhancement activities will occur in cooperation with the Division of Consolidated Laboratories (DCLS) under whose authority StarLIMS operates.

In addition, VGP will strengthen collaborative efforts with the Children with Special Health Care Needs (CSCHN) (VDH managed) and Early Intervention (Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) managed) programs to link children from the birth defects registry to needed resources. These include Care Connection for Children (CCC) -- a statewide network of regional centers that assist families in accessing health care services and provide care coordination, family-to-family support, and information and referral to resources to children with special health care needs (including those with inborn errors of body chemistry), and early intervention services through the Infant & Toddler Connection of Virginia.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				60	60
Annual Indicator			58.3	58.3	58.3
Numerator					
Denominator					
Is the Data					

Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	60	65	65

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Each clinic in the Child Development Clinic network (CDC) surveyed parents to determine their level of satisfaction with care received. Results ranged from 87-100 percent of parents or caretakers being very satisfied with the care received. Of the remaining parents, most were satisfied.

Family satisfaction surveys were mailed to clients in Central Virginia Care Connection for Children (CCC) with a 36 percent response rate. The majority of the comments were very positive. Forty-three percent of the persons who commented specifically mentioned the helpfulness of their child's CCC care coordinator. Other CCC centers and the Virginia Bleeding Disorders Program (VBDP) conducted less formal surveys with very positive comments from the families. VBDP hosted routine meetings of consumer advisory boards for three of the four hemophilia treatment centers.

Family representatives continued to serve on the Virginia Early Hearing Detection and Intervention Program Advisory Board, the Hemophilia (Bleeding Disorders) Advisory Board, and the Virginia Genetics Advisory Committee. Three Care Connection for Children centers maintained family resource libraries. All centers maintained a close working relationship with Virginia coordinators for Family Voices and Parent-to-Parent. The coordinators and parents within these groups provided consultation and training to staff and clients of the CCC centers.

The CSHCN Program participated in the National Institute for Children's Healthcare Quality (NICHQ) Medical Home Learning Collaborative. Parents of children being served by the practices were integral members of the three primary care practice teams participating in the Collaborative and establishing the medical home model.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Family members routinely serve on committees and advisory boards of the CSHCN Program.				**X**
2. Provide family-to-family support as a basic service of Care Connection for Children (CCC) centers.		**X**		
3. Collaborate with Family Voices and Parent-to-Parent to enhance family decision-making ability.				**X**

4. Administer parent satisfaction surveys at CCC centers, Child Development Clincs, and the Bleeding Disorders Program.				X
5. Monitor activities and outcomes; adjust CHSCN state plan for meeting 2010 goals as needed.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CDCs, CCCs, and VBDP continue to administer parent satisfaction surveys. VBDP continues to host routine meetings of consumer advisory boards for three of the four hemophilia treatment centers.

Families continue to serve on advisory boards of the CSHCN Program and participate in CCC activities. All centers are increasing their efforts in the provision of family-to-family support services.

c. Plan for the Coming Year

Families will continue to serve on advisory boards of the CSHCN Program and be members of CCC teams. All six CCC centers will have viable family-to-family support services. CDCs, CCC centers, and VBDP will survey families to determine their satisfaction with the services and make necessary changes to best meet identified needs. VBDP will continue to host routine meetings of consumer advisory boards for three of the four hemophilia treatment centers.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				60	60
Annual Indicator			54.5	54.5	54.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance	60	60	60	65	65

Objective					

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

In FY 04, 97.7 percent of the Child Development Clinic network, 100 percent of Care Connection for Children network, and 92.2 percent of the Bleeding Disorders Program clients had a primary care provider.

All children seen for CDC and CCC services were screened to determine if they had a primary care provider and, if not, were informed of choices to obtain one. CDCs established a goal to improve communications with the medical home by sending the clinic's final report to the medical home within fourteen days of the completion of the CDC team evaluation. The results ranged from three to ninety percent of the reports being mailed within fourteen days -- a CDC network average of 49 percent.

Three primary care practices along with a Title V team attended the third and last learning session in the NICHQ Medical Home Learning Collaborative and completed between-session assignments. To facilitate the spread of the medical home concept, those attending the Learning Collaborative formed the Virginia Medical Home Coalition to continue support of each other and to plan for ways to market the concept.

The CCC management team and the Division of Child and Adolescent Health Pediatric Screening and Genetics Services team monitored their plan for Virginia to meet Healthy People 2010 goals for CSHCN and made adjustments as needed. The plan includes numerous activities to establish medical homes and to assist families in the use of the medical homes.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with other community agencies to expand the availability of medical homes for CHSCN.				X
2. CCCs, CDCs, and the Bleeding Disorders Program work with families to ensure that children served are referred to a medical home.		X		
3. Contract with Medical Home Plus to provide training and technical assistance to primary care practices on the medical home concept.				X
4. Monitor activities and outcomes; adjust CSHCN state plan as needed.				X
5.				
6.				
7.				
8.				
9.				

10.

b. Current Activities

Sparked by participation in the national Medical Home Learning Collaborative, VDH has formulated and is now implementing plans to spread the medical home concept across the state. Pivotal to these plans is a strong partnership forged with the Virginia Chapter of the American Academy of Pediatrics and Medical Home Plus to assist with this activity. Medical Home Plus (MHP) is a private, nonprofit organization that provides services and support to parents of special needs children, as well as technical assistance and training to primary care practices in the medical home model.

VDH contracted with MHP to spread medical home implementation across Virginia, beginning with a forum this year, follow-up technical assistance to participating primary care practices (PCPs), and a second training event to be conducted next year. In April 2005, a Medical Home Forum was held for CCC staff and ten PCP "teams." Based on the national Medical Home Learning Collaborative model, each PCP team consists of a physician, a practice staff who performs care coordination duties, and a parent of a special needs child served by the practice. A unique aspect of this event is a pre-forum site visit to each of the practices registered for the forum. The primary purpose of these visits was to inform as many practice staff as possible about the objectives of the medical home initiative and create more widespread momentum for change within the practice. It also provided an opportunity to address questions regarding expectations of the practice should they choose to continue their involvement in post-forum technical assistance activities. On-site visits have been well attended and highly successful in engaging a larger number of practice staff beyond the "team" that will represent the PCP at the forum.

To date, there has been a good response to the offer of a Medical Home Forum for PCPs. The method of physician-to-physician recruitment appears to be an effective one. Incorporating pre-forum onsite visits to participating practices also appears to be a very effective means of "widening" the medical community's knowledge about medical homes. The number of physicians attending onsite luncheon presentations has been greater than expected. The visits also provide an excellent opportunity for educating practice staff about Title V services. Since the CCC program director for the region also attends these visits, a relationship between the PCP and CCC is initiated. Currently, thirteen PCP "teams" from three CCC regions are actively participating in follow-up technical assistance from MHP.

c. Plan for the Coming Year

MHP will continue to provide face-to-face follow-up technical assistance to participating PCPs, and a second major training event is being planned for next year. All children seen for CDC and CCC services will be screened to determine if they have a primary care physician and, if not, will be informed of choices to obtain one.

VDH will partner with the Department of Medical Assistance Services (DMAS) to increase provider knowledge of EPSDT services. The process will include conducting provider focus groups to assess the level of physicians' knowledge about EPSDT and the usefulness of DMAS training materials. DMAS will also provide training to medical providers to maximize reimbursement under EPSDT.

The CSHCN Program will continue to implement the plan for Virginia to meet Healthy People 2010 goals for CSHCN and their families. The plan includes numerous activities to standardize the core elements of the medical home; promote the medical home approach; achieve universal access to a medical home; and use the medical home as a measure of quality care. Specific activities have been designated and included in the VDH contractual arrangements with CCC centers and CDCs.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				67	68
Annual Indicator			65.6	65.6	65.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	70	70	75	75

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The CDCs and VBDP prepared their annual plans based on the six goals from 2010 Express and are contractually required to refer all eligible children without insurance to either Medicaid or FAMIS (SCHIP) and SSI and to follow-up with families to assure that the application is processed.

A major component of the CCC program is the provision of insurance case management to assist families in obtaining, understanding, and using health insurance. CCC staff participated in community groups to promote enrollment of uninsured children in public programs. CCC centers continued to refer 100 percent of potentially eligible children to Medicaid, FAMIS, and SSI programs and continued follow-up with families to assure that the application was processed. Central Virginia CCC established an agreement with Virginia Department of Medical Assistance Services for an expedited eligibility verification and enrollment process for FAMIS for "medically urgent" CCC clients. The center also established an agreement with a Medicaid HMO to fund a half-time care coordinator position to be housed at the center to coordinate care for the CSHCN enrolled in the health plan.

In FY 04, 94.5 percent of Child Development Clinic network, 91.8 percent of Care Connection for Children network, and 91 percent of the Bleeding Disorder Program clients had health insurance coverage. In addition, 8.3 percent of clients in all three programs received SSI.

In FY 04, 411 clients in CCC and VBDP received financial assistance from the CSHCN Pool of Funds. This Pool provides a limited amount of money to assist uninsured and underinsured clients to receive medical care that they otherwise could not afford. Covered services include durable medical equipment, medications, diagnostic testing, therapies, hospitalizations, and specifically for children with maxillofacial conditions, dental orthodontic and prosthodontic appliances.

The MCHIP CSHCN Health Insurance and Financing Grant continued to support project activities to improve access to comprehensive insurance benefits and services for CSHCN. The first pilot project was implemented in April 2004. The Parent-to-Parent director, in collaboration with Central Virginia CCC, developed a Care Coordination Notebook that focuses on providing information to parents about insurance programs, consumer rights, advocacy, and parent/professional relationships. The Notebook serves as a training tool for the parent trainers and a "working" guidebook for parents to maintain records of their child's health care.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CCCs, CDCs, and the Bleeding Disorders Program will refer 100% of eligible children to Medicaid, FAMIS, and SSI.		X		
2. Provide health insurance case management as a basic service of the CCC centers and Bleeding Disorders Program.		X		
3. Continue the MCHIP/CSHCN Health Insurance and Financing Grant to improve access.				X
4. Monitor activities and outcomes; adjust the CSHCN state plan as needed.				X
5. Work with other agencies to identify issues and remove obstacles that cause underinsurance.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CDCs, CCC centers, and VBDP continue to refer all potentially eligible children to Medicaid, FAMIS, and SSI programs and continue to follow-up with families to assure that the application is processed. They also continue to provide annual plans based on the 2010 Express goals for CSHCN. Clients continue to receive financial assistance from the CSHCN Pool of Funds.

The CSHCN Program is collaborating with the Virginia Leadership Excellence in Neurodevelopmental Disabilities program to examine the issue of underinsurance through the analysis of Virginia data from the National Children with Special Health Care Needs-State and Local Area Integrated Telephone Survey (CSHCN-SLAITS). Data from this analysis is providing additional feedback on areas of incomplete coverage for CSHCN.

The MCHIP CSHCN Health Insurance and Financing Grant continues to support project activities to improve access to comprehensive insurance benefits and services for CSHCN. Collaboration continues with the Virginia Chapter of the American Academy of Pediatrics and Medical Home Plus to promote the medical home concept among primary care providers. The Care Coordination Notebook is being revised to include more statewide resources. Virginia CSHCN staff is participating with other MCHIP Health Insurance and Financing grantees to develop a document examining the issue of underinsurance. Parent outreach staff will conduct outreach activities in the second CCC pilot region (Hampton Roads) to increase parents' awareness of Medicaid/FAMIS and encourage enrollment of eligible children.

The CSHCN Pool of Funds is being evaluated by region to identify areas of under-insurance and services/fees not covered by these funds. Additional information from the CSHCN- SLAITS is being used as appropriate for this evaluation. The CSHCN Program continues to work with the Department of Medical Assistance Services (DMAS) to identify issues and remove obstacles that cause underinsurance of CSHCN receiving Medicaid and FAMIS. Updated manuals and videoconference training by DMAS will be provided for CCC centers and CDCs to review Medicaid/FAMIS application procedures, discuss policy changes, and answer questions.

c. Plan for the Coming Year

CDCs, CCC centers, and VBDP will continue to refer all potentially eligible children to Medicaid, FAMIS, and SSI programs and continue to follow-up with families to assure that the application is processed. They will continue to provide annual plans based on the 2010 Express goals for CSHCN. Clients will continue to receive financial assistance from the CSHCN Pool of Funds.

The MCHIP CSHCN Health Insurance and Financing Grant will continue to support project activities to improve access to comprehensive insurance benefits and services for CSHCN. The executive director of Parent-to-Parent of Virginia will provide training sessions in the third CCC pilot region to increase parents' knowledge of insurance programs, issues, and consumers' rights to appeal denial of benefits and services. CSHCN Program will partner with DMAS to increase knowledge of employers and human resources personnel regarding public insurance programs, including the new FAMIS Premium program. Grant activities include collaborating with the MCHB Health Insurance grantee in New Hampshire to provide education/information to Anthem of Virginia regarding the NH Anthem/Primary Care Practice partnership and its effectiveness in reducing utilization costs for CSHCN.

The CSHCN Pool of Funds will continue to be evaluated by region to identify areas of underinsurance and services/fees not covered by these funds. The CSHCN Program will continue to work with DMAS to identify issues and remove obstacles that cause underinsurance of CSHCN receiving Medicaid and FAMIS. Updated manuals and videoconference training by DMAS will be provided for CCC centers and CDCs.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and					

Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				82	82
Annual Indicator			80.1	80.1	80.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83	85	85	88	88

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The CDCs annual planning process was revised to incorporate the six goals from 2010 Express. Each of the eleven clinics was asked to develop two new referral sources within their communities; offer trainings or technical assistance to other providers in the community; serve as training sites for social work, nursing, or psychology students; provide services to foster care children; and offer field clinics or other specialty clinics to strengthen the community-based service system. All clinics participated in these activities. All CDCs have developed close working relationships with the local school system, social service agencies, mental health agencies, and Head Start and early intervention programs.

In state FY 04, the CCC network served 4,894 clients. The Bleeding Disorders Program served 218 clients (157 persons birth to age 21 years and 61 persons 21 years of age and older). The CDC network provided multidisciplinary diagnostic evaluations, interpretative reports, and care coordination to 1,537 new clients. An additional 585 clients (new and follow-up) received initial assessments, consultation, treatment, and other follow-up services.

The Web site, www.specialneedsresourcesva.org, was maintained by the CSHCN Program for families and health care professionals seeking information and resources for CSHCN in Virginia. This resource directory allows query by diagnosis, major CSHCN issues, and region of the state.

The Bleeding Disorders Program updated its brochure for clients and families with inherited bleeding disorders and for health care providers seeking information and resources regarding inherited bleeding disorders. It also completed an outreach program for teen girls and women with bleeding disorders. The program received a grant award to develop an educational video on genetics counseling for persons with bleeding disorders.

In October 2003, care coordinators from all CCC centers received training on the provision of

care coordination services. Two nationally-recognized expert speakers presented the basics of the care coordination model of care for CSHCN, the national standards of practice for case management, and the process for national certification for case management. During 2004, a third CCC social worker became a certified advanced social work case manager by the National Association of Social Workers. A CCC program director became certified as a certified case manager (CCM) by the Case Management Society of America. This brings the total to seven (21 percent) CCC staff with case management certification.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide leadership in planning, developing, and implementing efforts to improve services for CSHCN.				X
2. Provide care coordination for CSHCN from birth through twenty years of age.		X		
3. CCC centers and the Bleeding Disorders Program will administer a CSHCN Pool of Funds.		X		
4. The Bleeding Disorders Program provides a system of services for people with bleeding disorders.	X			
5. CDCs provide diagnostic and evaluation services for children from birth through twenty years of age.	X			
6. CDCs partner with others to coordinate care for children with behavioral programs.		X		
7. Monitor activities and outcomes; adjust the CSHCN state plan as needed.				X
8. Participate in statewide committees and interagency councils for CSHCN issues.				X
9. Provide training and technical assistance.				X
10.				

b. Current Activities

The Blue Ridge CCC was implemented in January 2004, making the statewide network of six regional Centers of Excellence for CSHCN fully operational. This completed the four-year transition from the clinic model (Children's Specialty Services) to the care coordination model (Care Coordination for Children). The CSHCN Program has contracted with Virginia Commonwealth University for the Central Virginia region; Eastern Virginia Medical School for the Hampton Roads region; Inova Health Care Services for the Northern Virginia region; Roanoke Health District for the Roanoke Area region; and the University of Virginia (UVA) for the Blue Ridge region. The CSHCN Program is managing the center in Southwest Virginia. The regional Centers of Excellence for CSHCN facilitate access to comprehensive health and support services that are collaborative, family-centered, culturally sensitive, fiscally responsible, community-based, coordinated, and outcome-oriented to CSHCN and their families. The centers provide information and referral to resources, care coordination, family-to-family support, assistance to families with the transition from child to adult-oriented health care systems, and training and consultation with community providers on CSHCN issues.

Southwest Virginia CCC continued to collaborate with the UVA Office of Telemedicine to maintain the video equipment housed in the health district in which the center is located. The

equipment allowed the clients to be served locally and avoid making the eight-hour round trip to UVA.

CDCs continue to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and assure that the children with the greatest need are served. Clinics continue to provide annual plans based on the 2010 Express goals for CSHCN.

The CCC centers continue in their mission to develop family-centered, culturally competent, and community-based systems of referral and care and to simplify access to these systems for families.

The VBDP will develop assessment tools for a study to be completed in FY 06 of adults with hemophilia living in Virginia. Educational packets are being developed for new clients and seminars on coagulation updates are being held. The program has hosted a social work networking day for bleeding disorder program social workers throughout Virginia.

c. Plan for the Coming Year

CDCs will continue to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and assure that the children with the greatest need are served.

The CCC centers will continue in their mission to develop family-centered, culturally competent, and community-based systems of referral and care and to simplify access to these systems for families.

VBDP will complete and report on the Adult Study to the Hemophilia Advisory Board. Seminars planned include home infusion and coagulation update. Collaboration will continue with the Virginia Chapter of the National Hemophilia Foundation to facilitate training and networking events for clients. Consumer advisory boards will also be hosted.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective				5.8	5.8
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	6	7	8	10	10

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Four CDCs provided transition services to their clients. CDCs focus on serving younger children (under age 10) to identify developmental and behavioral problems as early as possible. Given a younger age group commonly served and the timeframe a child may be receiving services, the CDC role in providing transition services is limited. CDCs worked with their local school systems to identify unmet needs of middle school students in special education to aid in their transition to high school.

Virginia's plan to meet Healthy People 2010 goals for CSHCN includes numerous activities to facilitate the development of a transition system for CSHCN; assure that youth with SHCN participate as decision-makers and as partners; assure that youth have access to health insurance coverage; and ensure that youth have a medical home that is responsive to their needs. Specific activities have been designated for the centers to accomplish and have been included in their contractual arrangements with VDH. These include identification of all open cases of children age 14 years and above to prioritize the group for transition of health care, education, social, and employment needs. The CCC centers and Bleeding Disorder Program are identifying "adolescent friendly" specialists to assist with the transitions.

Training for the CCC care coordinators on their role in transitioning clients from the pediatric to the adult health care system was conducted in the fall 2004. National experts and community-based providers presented at the training. The CSHCN Program developed standards of practice for CCC care coordinators in the provision of transition services. A Transition Tool Kit was developed and one was provided to each CCC coordinator. The kit includes transition worksheets organized by aspects of transition to be used during encounters with the client and family. The worksheets help identify the client's strengths and challenges during the transition process and help measure progress toward transition over time. The worksheets are divided among five age groups between ages 14 and 21 years, aiming toward a minimum of five transition encounters between the client, family, and care coordinator. The kit included a sample emergency information form for families to complete and provide to caregivers, emergency rooms, day care providers, etc. A transition resource library was developed for each CCC with documents related to the health, education, employment, transportation, recreation, legal, financial, health insurance, and housing aspects of transition.

The Bleeding Disorders Program completed an outreach program for teenage girls with hemophilia. A "Girls Day Out" provided education and support to teens.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. CCCs and the Bleeding Disorders Program provide transition of services from pediatric to adult health care services.		X		
2. Monitor activities and outcomes; adjust the CSHCN state plan as needed.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CDCs, CCC centers, and the Bleeding Disorders Program continue to assist older children in the transition to adult care. Targeted activities in the plan for meeting this Healthy People 2010 goal include:

a. Investigate external funding sources to support the expansion of transitioning activities.
b. Facilitate interagency collaboration with the Department of Education, the Department of Rehabilitative Services, and the Department of Mental Health, Mental Retardation, and Substance Abuse Services to share resources and skills.
c. Collaborate with DMAS in their development of the Medicaid Buy-In Program for adults with disabilities.

The Bleeding Disorders Program is enhancing its transition services to older children by using the CCC transition standards of care. It has developed educational packets for clients transitioning to adult care. It is also piloting a transition checklist developed by the National Hemophilia Foundation.

c. Plan for the Coming Year

CDCs, CCC centers, and the Bleeding Disorders Program will continue to assist older children in the transition to adult care.

The CSHCN Program plans to partner with the Department of Education and Department of Rehabilitative Services in the planning and implementation of the state's 2006 Transition Forum. The program will also partner with the Virginia Board of Persons with Disabilities to promote the Board's Youth Leadership Forum for 2006.

VBDP will participate in the development of a hemophilia comprehensive care clinic for adults at the University of Virginia. Previously, UVA had only a pediatric clinic.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	75	77	79	82
Annual Indicator	70.7	74.9	72	84	
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	85	86	86	86

Notes - 2002

Data Source: 2001 National Immunization Survey. 2002 data not available.

Notes - 2003

National Immunization Program Data Calendar Year 2002 from CDC website

Notes - 2004

2004 Data not available.

a. Last Year's Accomplishments

In FY 04, Title V supported activities related to increasing immunization rates focused on the provision of child care health consulting activities, including assessment. The Title V Early Childhood Project director, along with the lead state child care health consultant, oversaw Healthy Child Care Virginia (HCCV) training and technical support activities for public health nurses and other professionals serving as child care health consultants. Key consulting activities are to provide CASA immunization audits and help child care centers institute system changes to support all attendees reaching and maintaining up-to-date immunizations. The director provided consultation to the Department of Social Services to work with child care providers in developing their knowledge and ability to assure complete immunizations among child care attendees. A part-time contracted coordinator provided ongoing consultation and technical assistance to the field. Several health districts (Rappahannock, Virginia Beach, and Hampton) used Title V funds to support activities related to increasing immunization rates through assessment and child care health consultant activities.

Title V supported several state and local efforts to provide parents and caregivers with information about immunizations. The Governor's New Parent Kit was piloted in spring 2004 in Tidewater and Southwest areas of the state. The kit contains a broad array of information related to infant and child care, and was distributed to 1,536 parents (reaching 70 percent of births during the pilot). VDH Resource Mothers, along with partners CHIP of Virginia and Healthy Families, led distribution efforts. The kit contains the Bright Futures Health Record and a customized Baby's First Year calendar highlighting immunizations needed for each month including stickers to put on dates received and the toll-free VDH Division of Immunization information line. Chesterfield and Prince William health districts used Title V funds for outreach and education activities geared to increase up-to-date immunizations.

Title V funds also support case management activities that help increase immunizations. Resource Mothers, a lay support program available in 87 communities, continued to assist teen

parents in getting their infants properly immunized. Roanoke health district used some of their Title V allocation to support their CHIP case management program for low income children ages 0-5. In FY 04, 90 percent of Roanoke CHIP enrollees were up-to-date at age two for the basic series (4:3:1:3).

Other statewide activities administered and funded through other sources included provision of immunizations through all local health departments; development and implementation of local immunization action plans; collaboration with public and private sector partners such as WIC and Medicaid HMOs; and surveillance, CASA assessment and evaluation activities led by the VDH Division of Immunizations, Office of Epidemiology.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide funding to local health districts to deliver child care health consultation services to help increase immunization rates.			X	
2. Promote Bright Futures Guidelines to increase utilization of preventive health care.				X
3. Support home visiting program such as CHIP of Virginia and Resource Mothers.		X		
4. Participate in Project Immunize Virginia Coalition.				X
5. Collaborate with stakeholders to publish information regarding immunization requirements.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Title V supported activities continue a major emphasis on working with child care providers to improve immunization rates and other health indicators. The Early Childhood Project director and part-time coordinator conducted two trainings in FY 05, increasing the number of child care health consultants to 189 statewide. With Title V funding, eight health districts are conducting child care health consultant activities to improve immunization status in all tiers of child care. Districts review FY 04 CASA results to determine how they can work with local child care providers to improve rates within their areas. Education, training, and outreach activities for child care and Head Start staff to monitor immunization records are being conducted to assure that 80 percent of two-year-olds are adequately immunized.

Title V continues to partner with the Virginia Department of Social Services (DSS) in reaching child care providers. In collaboration with DSS, a 2005 calendar customized with health, safety, development, and Virginia resource information was printed and distributed to 15,000 child care providers. In another effort with DSS and the Head Start Collaborative Project, the Healthy Child Care Tool Kit is being distributed to 5,000 child care providers of all levels. This kit contains information, resources, and curriculum on items such as control of communicable disease, emergency preparedness, safe sleep environments, nutrition and physical activity, the importance of a medical home and health insurance, medication administration, and asthma. The kit provides the Bright Futures pocket guide that outlines required immunizations. Kits are

distributed through face-to-face trainings statewide by child care health consultants. Attending providers receive continuing education credits required by DSS licensing. Preliminary evaluation of over 400 attendees found that 49 percent were teachers and 30 percent were owners/directors of child care sites. Twenty-four percent of participants were from family day homes, 49 percent from licensed facilities, and the rest were from other child care settings (e.g. faith-based). Overall, participants felt the kit's content met their needs for working with health-related issues in child care. Lastly, a quarterly Healthy Child Care newsletter is mailed to 10,000 child care providers throughout the state. Topics focus on timely issues including importance of immunizations and keeping children's medical records up-to-date, health insurance, disease prevention, and working with children with special health care needs.

Since the statewide launch in FY 05, 50,000 Governor's New Parent Kits have been provided to community partners for distribution. The New Parent Kit, geared for parents or other primary care givers, contains several items providing immunization information and resources. Resource Mothers continue distributing these kits and provide support for teen parents to ensure their infants are adequately immunized.

c. Plan for the Coming Year

The part-time child care health consultant will continue providing technical assistance to field staff through the end of the Healthy Child Care Virginia funding in midyear FY 06. To build sustainability, child care health consulting has been incorporated as a working committee under the VDH Nursing Council. Consultation and partnering with Project Immunization Virginia, the VDH Division of Immunization, Head Start Collaborative, and the DSS Divisions of Child Care Programs and Licensing will continue to assist with infrastructure building activities.

In FY 06, eleven local health districts -- Central Shenandoah, Chesterfield, Hampton, Hanover, Lord Fairfax, Norfolk, Peninsula, Piedmont, Portsmouth, Rappahannock, and Southside -- plan to use some of their Title V allocation to support child care health and safety.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	21.6	21	20	19	19
Annual Indicator	21.4	21.0	18.9	17.4	
Numerator	2957	2906	2746	2570	
Denominator	138386	138386	144931	147701	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance	19	19	19	18	17

Objective					

Notes - 2002

The data source is Virginia Center for Health Statistics. The 2002 birth data will be available at the beginning of 2004

Notes - 2003

The 2003 birth data is not yet available from VA center for health statistics

Notes - 2004

2004 Data not available. . .

a. Last Year's Accomplishments

In FY 04, the Teenage Pregnancy Prevention Initiative (TTPI) was funded solely through DSS TANF funding. Teenage pregnancy prevention programs were staffed and monitored. Each program implemented curriculum identified as a best practice or effective program. Quarterly meetings were held for information dissemination, training, and networking. Staff worked in conjunction with VCU-SERL on the TPPI evaluation. A Master Evaluation Protocol (MEP) was completed which will enable us to begin standardizing outcome data collection across programs. The Better Beginnings Coalitions (BBCs) were funded and monitored. These coalitions worked to increase awareness and implement community approaches geared for prevention of teenage pregnancy through youth development, media, and other methodologies. Title V funds were used to support teenage pregnancy prevention strategies in the Central Shenandoah, Central Virginia, Cumberland Plateau, Hampton, Lenowisco, Lord Fairfax, Mount Rogers, Peninsula, Piedmont, Rappahannock, and Richmond health districts. The second annual evaluation conference was held to explore current trends in teenage pregnancy prevention programming and research with an emphasis on national, state, and local levels.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide oversight of teenage pregnancy prevention programs in seven health districts.				X
2. Fund Better Beginnings Coalitions (BBC) in 19 communities.		X		
3. Evaluate teenage pregnancy prevention programs.				X
4. Fund and support teenage pregnancy prevention strategies in local health districts.	X			
5. Support statewide train-the-trainer workshops to help parents talk with their children about sensitive topics including sexuality (e.g., "Can We Talk" curriculum and "Talk2Me Toolkit").			X	
6. Continue efforts to integrate HIV, STD, and teen pregnancy prevention messages.				X
7. Develop the statewide adolescent sexual health plan.				X
8. Develop the skills and capacity of youth service providers to serve the target population through information networks.				X
9.				
10.				

b. Current Activities

TPPI continues operations in the seven health districts specified by the Virginia General Assembly in 1993 and 1994. Funding for the program has shifted entirely to DSS TANF funds

as designated in the state budget. Quarterly meetings, convened in collaboration with the Virginia Abstinence Education Initiative, are held for information dissemination, training, and networking. Staff members are collaborating with VCU-SERL on the TPPI evaluation. The BBCs continue to develop increased awareness and implement community approaches to the prevention of teenage pregnancy through youth development, media, and other methodologies.

Title V funds are supporting teenage pregnancy prevention strategies in Lenowisco, Piedmont, and Rappahannock health districts. Each of these programs has submitted a work plan and targets using the outcome funding model. Information and promotion of the National Day to Prevent Teen Pregnancy on May 4, 2005 is being provided to all field programs and health districts. A training day for program providers is scheduled for May 20, 2005.

The Divisions of Child & Adolescent Health, Women's and Infants' Health, and HIV/STD Prevention and others are collaborating to integrate teen pregnancy, STD, and HIV prevention efforts wherever possible; this group meets monthly. Programmatic areas currently involved are abstinence education, adolescent health, family life education, family planning, HIV/STD, resource mothers, juvenile justice, foster care services, and teenage pregnancy prevention. To date, this group continues to offer "Can We Talk" train-the-trainer sessions (designed to encourage parents to talk with their children) to local teams and is scheduling six regional stakeholder meetings to assist program providers in planning future integration efforts.

c. Plan for the Coming Year

The General Assembly appropriated level funding for the Teenage Pregnancy Prevention Initiative for FY06. Each TPPI program will be required to implement a curriculum identified as a best practice or effective program. Quarterly meetings will be held for information dissemination, training, and networking. Staff will continue to work in conjunction with VCU-SERL on the TPPI evaluation. Better Beginnings Coalitions (BBCs) will continue to be funded and monitored. BBCs work to increase awareness and implement community approaches geared toward the prevention of teenage pregnancy through youth development, media, and other methodologies. The development of a collaborative work plan will be continued to include an expansion of the agencies and programs participating.

In FY 06, Title V funds will not be used to support teenage pregnancy prevention programming at the health district level. An evaluation conference will be held to explore current trends in teenage pregnancy prevention programming, and staff from health districts will be included along with funded program providers.

An expansion of the parent support and communications materials is being planned to include a CD-Rom for talking with teens about sexually transmitted diseases and a Spanish version of the "Talk 2 Me - A Guide for Discussing Sexuality and Relationships with Your Kids." Web-based training modules will be developed for professionals interested in abstinence education, teenage pregnancy prevention, and related adolescent sexual health issues.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	30	30	35	36	37
Annual Indicator	32	32	32	32	32
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	39	40	42	44	46

Notes - 2002

Data Source: 1999 Statewide 10 Year Dental Needs Assessment. Statewide dental data not available until needs assessment completed again in 2009.

Notes - 2003

Data Source: 1999 Statewide 10 Year Dental Needs Assessment. Statewide dental data not available until needs assessment completed again in 2009.

Notes - 2004

Survey not done in 2004. . .Use previous value...

a. Last Year's Accomplishments

The Division of Dental Health (DDH) supported local health department dental programs through the Title V-funded quality assurance program. Last year, on-site quality assurance reviews were provided for dental programs in the following local health districts: Mount Rogers, Virginia Beach, Western Tidewater, Rappahannock/Rapidan, Chesterfield, and Cumberland Plateau. Technical assistance was also provided for a new dental program in Rappahannock Health District. VDH dental clinics served 25,749 individuals in FY 04. Out of 46,501 total visits, 25,749 visits were provided. More than 203,000 clinical services, including 27,000 dental sealants, were provided for these patients at a value of almost $12 million. Training was provided for 100 dental staff in 24 health districts regarding pediatric dentistry and other public health dental topics during a two-day meeting. Additionally, staff were trained regarding anticipatory guidance and the fluoride varnish technique during a teleconference. Two districts, Norfolk City and Thomas Jefferson Health District, used Title V funds to support their dental programs. Norfolk City provided 500 visits for preventive services including dental sealants and Thomas Jefferson Health District provided 126 preventive and comprehensive care visits and education to 200 children in day care.

Title V funds also provided materials for more than 50,000 children to participate in the school-based fluoride mouthrinse program. All program participants are using pre-mixed fluoride. The VDH dental hygienist, funded by Title V, provided training to children, teachers, and nurses and conducted on-site reviews of half of the 200 participating schools statewide.

Dental health education training was provided to customers including Head Start programs, school nurses, and VDH dental staff. Materials developed to meet the statewide Standards of Learning (SOL) for oral health were piloted in several health districts. Educational assistance regarding oral health was given to the Department of Education for the PASS program, which targets schools that are not currently meeting the SOL standards. VDH dental health brochures regarding dental sealants, flossing, brushing, oral health, well being, nutrition, and dental health were utilized in these trainings.

DDH partnered with the statewide dental coalition, Virginians for Improved Access to Dental Care, to hold a dental health summit September 29-30, 2003, resulting in the development of a state oral health plan.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Two districts are using funds to provide treatment, including dental sealants for eligible school children.	X		X	
2. The school fluoride rinse evaluation includes surveying 1,000 children with regard to decay status and sealants.			X	X
3. The School Rinse program provides fluoride to 50,000 children in 200 schools without access to community water fluoridation.			X	
4. Quality assurance is provided each year to one-third of dental programs statewide and includes on-site clinical and community review.				X
5. Educational materials in multiple languages are provided to local health department dental programs, Head Start program, and school nurses.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Title V provides funding for local health departments for dental services including dental sealants and education. DDH currently provides technical assistance to local public health dentists on preventive/comprehensive dental care including the placement of sealants. DDH also provides on-site quality assurance reviews of local health department dental programs and training for staff. To date, site visits have been conducted in Alleghany, Western Piedmont, Alexandria, and Arlington Health Districts for this fiscal year. DDH is also working on a centralized recruiting system for local health department dentists, which has filled four positions this fiscal year. Orientation has been provided to staff in Central Shenandoah and Norfolk.

The school fluoride program is currently implemented in 50 counties. During the current year, it is expected that more than 50,000 children will participate in the school fluoride program. Site visits and training year have been completed in approximately one half of the participating schools this fiscal year.

DDH continues to develop and distribute dental health education materials. The focus of materials this year has been on sports activities and mouthguards and oral piercing as DDH renews oral health initiatives focused on adolescent health. Dental health education training was provided to customers including Head Start programs, school nurses, and VDH dental staff. Materials developed to meet the statewide Standards of Learning for oral health were expanded to additional grade levels.

An epidemiologist has been hired for the division to work on program evaluation and

assessment. Work is currently proceeding on the analysis and report of a statewide needs assessment.

Community water fluoridation has been supported through a coordinator. In addition to working with communities on upgrading or initiating fluoridation, a campaign is underway to targets individuals living in areas of high natural fluoride. A brochure will be provided to those children below nine years of age who are most susceptible to dental fluorosis.

c. Plan for the Coming Year

In addition to ongoing activities in prevention areas including community water fluoridation, school fluoride rinse, and education, local health department dental programs will provide dental treatment and preventive services including sealants in approximately half of Virginia's cities and counties. Supplemental funding from Title V will assist Alleghany, Roanoke City, Central Virginia, Piedmont, Norfolk, and Peninsula in providing additional preventive services including sealants and education. There will be ongoing quality assurance site reviews in twelve districts in addition to monitoring those districts with supplemental funding. Technical assistance to the local health districts will continue, including a centralized recruiting initiative to attract dentists into VDH positions. A new program for dentist loan repayment will be administered this year in addition to the dental scholarship program. The dentist loan repayment program will be funded for the first time this fiscal year by general funds allocated through the 2005 General Assembly. The goal of these programs is to place dentists in underserved areas of the state.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	3.2	2.5	2.1	2.1	2.1
Annual Indicator	2.5	2.1	2.7	2.7	
Numerator	36	31	40	41	
Denominator	1453021	1453021	1482240	1496098	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.1	2.1	2.1	2	2

Notes - 2002

Data Source: Virginia Center for Health Statistics. The 2002 mortality data will be available at the beginning of 2004

Notes - 2003

The 2003 injury death data file is not yet available from VA center for health statistics.

Notes - 2004

2004 data not available. . .

a. Last Year's Accomplishments

Title V funds supported the Center for Injury and Violence Prevention (CIVP) in providing oversight to staff that manage a statewide transportation safety and child restraint installation and education program, which is funded through state revenue funds and a federal highway safety grant. CIVP continued to coordinate a statewide child safety seat distribution and education program for low-income families carrying out the following activities: operating 120 distribution sites statewide, distributing 10,000 child safety seats, and coordinating an annual statewide observance of child passenger safety week. CIVP coordinated a network of safety seat trainers and technicians who implement child safety seat check events around the state. CIVP coordinated a child passenger safety radio campaign specifically targeted at fathers during the child passenger safety week observance in February. CIVP disseminated a large variety of child passenger, bike, and pedestrian safety education materials to community providers through our injury prevention resource center and web site. Title V supported the Virginia Child Fatality Review Team (CFRT). The CFRT initiated a review of 2002 motor vehicle deaths to children and a review of all hyperthermia/hypothermia deaths of children who had been left in cars for the period 1988-2003.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child restraint device dissemination.		X	X	
2. Public and provider education campaigns.		X		
3. Child safety seat check events.		X		
4. Buckle up campaigns for high schools.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CIVP is continuing to transition trainers and technicians to a new national certification process. CIVP is disseminating a child passenger safety video for new parents developed by CIVP, Virginia Association of Chiefs of Police, and the Department of Motor Vehicles to all maternity hospitals as part of CIVP's "First Ride Safe Ride" campaign aimed at promoting hospital policies and practices that ensure safe transportation of newborns. CIVP is adding education about the dangers of leaving children unattended in vehicles to all of its child passenger safety training and educational information. CIVP is increasing the number of distribution sites to 130 for the statewide child safety seat distribution and education program for low-income families to better meet the growing demand. This year, the low-income child safety seat distribution and education program has made a significant policy change to allow children ages 1-3 eligible to apply for a safety seat. The CFRT is continuing its review of hyperthermia-related injuries to children left unattended in cars and will publish a report.

c. Plan for the Coming Year

CIVP will continue to disseminate child restraint devices and collaborate with state highway safety partners to implement a variety of strategies to involve Virginia's parents, youth, and the general public in motor vehicle injury prevention.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	75	75	75	78
Annual Indicator	64.3	67	67	70	
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	79	80	80	80

Notes - 2002

The data is collected based on an annual survey conducted by Ross Lab. The numerator and denominator are not available for 2002.

Notes - 2003

The data is collected based on an annual survey conducted by Ross Lab. The most recent data is from the 2002 survey. The numerator and denominator are not available for 2002 and 2003.

Notes - 2004

2004 data not available.

a. Last Year's Accomplishments

The Virginia Breastfeeding Task Force continues to serve as a vehicle for promoting breastfeeding at both the state and local levels. The Task Force continues to develop materials and support breastfeeding through attendance and participation at conferences.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. The Breastfeeding Peer Counselor was hired in July 2004.		X		
2. The Breastfeeding Peer Counselor Coordinator and Nutrition Manager completed "Using Loving Support to Implement Best Practices in Peer Counseling Training" in July 2004.		X		
3. Local agencies have been selected as pilot sites for the Peer Counselor programs.				X
4. Staff from local agency pilot sites will receive training for implementation of the program in May 2005.				X
5. Peer counselor training manuals are presently being revised and will be available to the pilot sites.				X
6. Governor Mark Warner issued a proclamation in support of Breastfeeding Awareness Month in August 2004.				X
7.				
8.				
9.				
10.				

b. Current Activities

During FY 2004, the Division of WIC & Community Nutrition Services was awarded funding fro the United States Department of Agriculture to implement an effective and comprehensive peer counselor program. The State Breastfeeding Counselor Coordinator was hired in July 2004. The Breastfeeding Peer Counselor Coordinator completed Using Loving Support to Implement Best Practices in Peer Counseling training in July 2004 and local agency staff will be attending this training in May 2005. The local agency pilot sites for Breastfeeding Peer Counselor programs have been chosen. The Peer Counselor Program training manuals are being revised and will be available to the pilot sites for this project.

In August 2004, Governor Mark Warner issued a proclamation in support of Breastfeeding Awareness Month. A press release for Breastfeeding Awareness Month was developed and available for local agencies.

c. Plan for the Coming Year

VDH will now focus on establishing a State-wide Breastfeeding Advisory Committee. While the VBTF may well continue to exist independently, VDH will focus on creating a more permanent and representative Advisory Committee. The new committee will include specifically designated representatives of professional medical organizations (APA, ACOG, Virginia Hospital Association, etc.) and high level stakeholders with interest in breastfeeding from throughout the Commonwealth. Effort will be made to gain wider representation from other areas such as public education, workplace, insurance, day care centers, and research as well. The Breastfeeding Advisory Committee will build upon the works of the VBTF and establish a broad base with which to increase breastfeeding rates in the Commonwealth. In addition, the Committee will be actively involved in Obesity Prevention efforts in the Commonwealth through increased breastfeeding.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	95	98	100	100
Annual Indicator	84.5	95.1	97.2	96.2	
Numerator	81736	91849	94206	94601	
Denominator	96759	96535	96870	98328	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

2002 hospital discharges data are not available.

Notes - 2003

Data for 2002 are from the Virginia Early Hearing Detection and Intervention Program (numerator). The denominator is from the Virginia Center for Health Statistics (occurrent births) and equals the number of infants born in Virginia hospitals. Data for 2003 are not available at this time.

Notes - 2004

2004 data not available.

a. Last Year's Accomplishments

During FY 04, the Virginia Early Hearing Detection and Intervention (VEHDI) Program continued to administer the state's newborn hearing screening program as required by the Code of Virginia. VEHDI carried out the following activities: (1) piloted the Virginia Infant Screening and Infant Tracking System (VISITS) At Risk Module; (2) conducted five regional training sessions for hospital staff; (3) established an enhanced voice mail system for the toll-free line, translated into four languages other than English; (4) conducted an evaluation of the VISITS At Risk Module and developed a plan for implementation statewide; (5) translated the parent brochure in five additional languages; and (6) provided newborn hearing flyers for the New Parent Kit to be distributed to all new parents in the state.

Additionally, the VEHDI Program participated in several teleconferences with program managers from Pennsylvania, West Virginia, Maryland, Delaware, and Washington, DC to discuss obtaining data on resident newborns delivered in neighboring states. Virginia has received one commitment from one out-of-state hospital newborn hearing screening program director to report resident infants who fail the initial screen. Half of the births at this facility are to Virginia residents.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Enhance, implement, and evaluate the Virginia Early Hearing Detection and Intervention Program.				X
2. Maintain the Virginia Infant Screening and Infant Tracking System database.				X
3. Provide training and education opportunities for hospital staff.				X
4. Provide hospitals with quarterly updates on program strengths and areas of need.				X
5. Monitor all newborn hearing screenings and ensure retesting as needed.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY 05, the VEHDI Program continued to be administered as mandated through state law. Hospitals continued to screen all newborns for hearing loss prior to discharge and to report required data through VISITS, the web-based integrated tracking and data management system. Ongoing program evaluation was conducted and hospitals continued to receive quarterly reports on their screening rates. In addition, the VEHDI Program continued technical assistance and training efforts for hospital staff, primary medical care providers, and audiologists to improve newborn hearing screening and reporting of screening and follow-up. The VEHDI Program continued networking with other state programs and bordering providers to explore reporting arrangements for resident infants born in neighboring states.

The Pediatric Screening and Genetic Services (PSGS) unit applied for a three-year CDC grant entitled Early Hearing Detection and Intervention Tracking, Surveillance, and Integration. If awarded, the grant would begin 7/1/05. Funds were requested to support the Virginia Child Health Information Systems Integration Project (VaCHISIP) to (1) enhance the VEHDI Program's capability for accurately ascertaining the disposition of every occurrent birth for each step throughout the EHDI process and (2) expand the integration of the program's tracking and surveillance system with other child health programs that identify children with special health care needs. If awarded, during FY 05, the VEHDI Program will collaborate with other VDH programs to initiate activities for achieving the following VaCHISIP goals: (1) produce and implement a redesigned VISITS application (VISITS II)--which includes VEHDI Program, VaCARES-the state birth defects registry, and At-Risk Referrals surveillance databases; (2) use VISITS II surveillance data to guide and support child and adolescent health clinical and programmatic decisions; and (3) electronically integrate and link together VISITS II and other child health information surveillance systems, including LeadTrax-the database for all children under six receiving blood lead level screenings and CCC-SUN-the patient management database used by the Title V Care Connection for Children CSHCN Program. In addition, PSGS applied for a HRSA grant to improve follow-up rates and reach goals of hearing screening of all infants prior to one month of age, diagnostic audiology performed by three months of age, and enrollment of appropriate cases into early intervention by six months of age.

VEHDI recently established the Virginia Hearing Aid Loan Bank (VHALB) using funds from a four-year federal Maternal and Child Health grant. Select digital/programmable hearing aids and FM systems are now available for loan to children with hearing loss who are under the age of three. The loan period is six months and all children under the age of three with hearing loss are eligible, regardless of income status.

c. Plan for the Coming Year

In FY 06, the Virginia EHDI Program will continue to be administered as required by the Code of Virginia. During FY 06, VEHDI staff will conduct quarterly teleconferences with hospital staff with a focus on reporting requirements and communication with families. Dissemination of quarterly status reports to hospitals will continue so that they may institute necessary quality improvements. VEHDI staff will collaborate with Delta Zeta and their national initiative to educate primary care providers and obstetricians about EHDI. The VEHDI Program will continue to be involved in VaCHISIP collaborative activities, which include participating on the Project Steering Committee and End User Groups. These groups will work with the Project Development Team to (1) identify, match, collect, and report standardized unduplicated individual identifiable data for every occurent birth via VISITS II; (2) improve VISITS II authenticated role-based Web access reporting efficiency, quality of data, and security; (3) develop an analytic plan to use VISITS II reports of unduplicated individual identifiable EHDI data to obtain outcome data; (4) improve the tracking and surveillance of program-targeted conditions (i.e., children with hearing loss, birth defects, risk for developmental delay) using VISITS II data; (5) disseminate timely and comprehensive data to healthcare professionals, policymakers, and other stakeholders; (6) improve Care Connection for Children and Lead-Safe Virginia case ascertainment; (7) complete a feasibility study on linkages with other statewide child health databases (e.g., Immunization Registry, WIC, and Medicaid); and (8) complete a VaCHISIP manuscript--which will include redesign processes, data reports utilization, and integration/linkages outcomes--and disseminate it to other state/territories, the CDC, and other federal and national agencies.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7	7	6	5	5
Annual Indicator	10	7	4.9	6.4	6.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	5	5	5	5

Notes - 2002

2002 data is not available. The data will be updated when SLAITS module is released.

Notes - 2003

Data are from the SHADAC State Planning Grant 2004 study for children under age 18.

Notes - 2004

Data not available at this time.

a. Last Year's Accomplishments

In FY 04, Title V program staff continued collaborations with state and local partners such as the Department of Medical Assistance (DMAS), the Department of Social Services (DSS), local health districts, school health personnel, the WIC program, Healthy Child Care Virginia (HCCV), and regional Care Connection for Children (CCC) centers for CSHCN to decrease the percent of uninsured children with an emphasis on outreach to potential eligibles for Virginia's Children's Health Insurance Programs (FAMIS Plus/Medicaid and FAMIS/SCHIP) known under the FAMIS umbrella.

Outreach and application assistance was integrated into VDH operations where possible. The CSHCN Program continued to contractually require CCC centers and Child Development Clinics (See NPM #4) to identify potential eligibles and assist families with obtaining health insurance. Other programs serving children and families, such as Resource Mothers, Baby Care, Healthy Start and the Virginia Early Hearing Detection and Intervention Program provided referrals or application assistance for FAMIS programs. HCCV and child care health consultants gave information on children's health insurance programs and promoted the importance of having health insurance and a medical home.

VDH and DMAS partnered on plans for an information technology enhancement to WebVISION, the local health district patient data system. WebVISION data will be used to start a FAMIS application for potential eligibles to be faxed to DMAS. Future phases include electronic data transmittal. State partners and local health district staff met to guide local business flow and product development.

In FY 04, ten health districts -- Alexandria, Chesterfield, Cumberland Plateau, Hampton, Lord Fairfax, Norfolk, Prince William, Richmond, Roanoke, and Virginia Beach -- used Title V funds to support local insurance outreach efforts and linkages to medical homes. Together they facilitated enrollment for 1,800 children.

VDH participated in statewide events such as Cover The Uninsured Week, led by DMAS to provide local health departments with promotional materials including a waiting room video. The VDH State Health Commissioner and other staff attended a Governor's event celebrating the net enrollment of nearly 100,000 children into FAMIS programs since late 2002. Supported by Title V, the Governor's New Parent Kit piloted in FY 04 contained FAMIS enrollment information and promoted the KIDS TLC toll-free line giving callers the option to apply for FAMIS over the phone.

Title V staff served on the primary statewide Covering Kids and Families (CKF) coalition and its task forces, funded by the Robert Wood Johnson Foundation, to support outreach and streamline efforts for enrollment, increase access and utilization of services, and retention.

Title V staff participated in the HRSA State Planning Grant led by the VDH Office of Health Policy. Staff provided input to the data workgroup on a state survey to measure health insurance status and ac

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Collaborate with partners to increase enrollment in state-sponsored health insurance programs.		X		
2. Participate in initiatives and coalitions aimed to reduce uninsured rates.				X
3. Fund local health districts for outreach and enrollment activities.		X		
4. Support surveillance, monitoring, and dissemination of data related to children's health and insurance status.				X
5. Implement data system enhancement to generate public insurance application for potential eligibles served in local health districts.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Collaborative efforts continue with state and local partners such as the Department of Medical Assistance (DMAS), the Department of Social Services (DSS), local health districts, school health personnel, the WIC program, Healthy Child Care Virginia (HCCV), and regional Care Connection for Children (CCC) centers for CSHCN to decrease the percent of uninsured children with the continued emphasis on outreach to potential eligibles for Virginia's Children's Health Insurance Programs (FAMIS Plus/Medicaid and FAMIS/SCHIP). Outreach, information and application assistance continue among VDH programs where possible. Efforts among state partners are moving to broaden efforts related to retention and utilization of health insurance.

VDH and DMAS are partnering on the WebVISION-FAMIS application enhancement link. VDH's Office of Information Management has developed this enhancement with Title V financial support. A link appears on the health department registration screen for potentially eligible children. Activating the link populates a FAMIS application and gives users options to add data needed to complete the form. Patients may also complete the form while waiting for services. VDH will fax completed applications and available income verification to the DMAS Central Processing Units. Training for six pilot districts has been held with pilots scheduled to run April through June. Statewide implementation will transpire late summer 2005. Two videoconferences will be held during Cover the Uninsured Week to provide health districts and other interested parties with information on the project.

Alexandria, Chesterfield, Cumberland Plateau, Norfolk, Richmond, Roanoke, and Virginia Beach are using some of their Title V allocation to support outreach, referral, and enrollment efforts. Local health departments completed a survey on services provided this year. The results showed that 90 percent provide basic screening and referral for health insurance and 60 percent reported they provide more intensive assistance such as helping complete applications and troubleshooting during the application process. Several districts work with local outreach projects and one district receives outside funding to conduct activities.

Title V staff continue to serve on the statewide CKF coalition and its task forces related to outreach and utilization of services. Title V staff continued serving on the HRSA State Planning Grant (SPG) data workgroup. Survey data from the grant-sponsored telephone household survey were reviewed from the child health perspective. Although not directly comparable to other similar surveys, data on the level of uninsured children among low income groups (5 percent among those 133 percent FPL and lower and 15 percent among those between 134-200 percent FPL) were lower compared to other previous survey data and appear congruent with levels of increased enrollment in FAMIS. Policy options of this grant will be focused on the

adult population.

c. Plan for the Coming Year

VDH will continue to collaborate with state and local partners. VDH programs will continue to integrate outreach, education, and application assistance where feasible. Title V staff will continue serving on the statewide CKF coalition and task forces. Title V staff will also continue serving on the HRSA state planning grant. VDH will provide representation to the Children's Health Insurance Advisory Committee.

Work on future phases of the WebVISION-FAMIS application link will continue. Statewide implementation will be monitored. The ability for pregnant women to apply will be added to the application link once DMAS enacts new mandates approved in the 2005 General Assembly raising Medicaid eligibility for this population to 150 percent Federal Poverty Level. When DMAS completes a planned one page application for yearly renewal, this ability will also be incorporated into the application link. Electronic transmission of application from WebVISION directly to DMAS will also be addressed.

In FY06, eight health districts -- Alexandria, Central Virginia, Chesterfield, Cumberland Plateau, Lenowisco, Norfolk, Roanoke, and Virginia Beach -- will use some of their Title V allocation to support outreach, referral, and enrollment efforts.

VECCS will be moving from planning to implementation with their state strategic plan. This blueprint will address cross-system issues and move from planning to implementation.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	84	85	80	82	84
Annual Indicator	79.4	74.9	78.5	86.0	
Numerator	360927	357100	367315	407845	
Denominator	454553	477075	467712	474478	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88	88	89	89	90

Notes - 2003

Numerator = Annual unduplicated recipients receiving a service from Department of Medical Assistance Services (DMAS) FY 2003 Statistical Record HCFA 2082 series

Denominator = Medicaid enrolled (eligibles from page 2-12 FY 2003 DMAS Statistical Record + estimated eligible not enrolled for Medicaid.

Notes - 2004

2004 Data not available.

a. Last Year's Accomplishments

DCAH collaborated with DMAS to revise the EPSDT manual to incorporate the periodicity schedule included in Bright Futures (used as the standard of care for VDH). DCAH conducted regional trainings for health department staff (clinic and WIC) and school nurses to promote EPSDT screenings using Bright Futures Guidelines. Emphasis was given on conducting developmental screenings.

In FY 04, Alexandria, Hampton, and Norfolk health districts continued use of Title V funds to support the infrastructure to deliver comprehensive primary care to children including EPSDT screening. Cumberland Plateau also continued conducting EPSDT screenings through the school setting with Title V support.

The Bright Futures co-chair consulted with Georgetown University and worked with the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services and the Department of Social Services to design staff training specific to mental health screening and referral based on Bright Futures Guidelines. The pilot training was provided in three sites for foster care workers and mental health clinicians.

VDH collaborated with DMAS to conduct statewide trainings for health professionals regarding both programmatic and billing details related to the EPSDT program. The goal of these trainings was to help ensure accessibility and quality for children served by DMAS. These trainings reached an additional health professional audience in the far southwest area of Virginia through the use of video conferencing technology. In addition, the Joint Subcommittee Studying Lead Poisoning Prevention initiated legislation that required the Office of the Secretary of Health and Human Resources (OSHHR) to establish a task force to conduct an examination of issues related to the EPSDT program. The study was completed and issues were addressed that included EPSDT protocols, delegation of EPSDT tasks to nurses, and the need for possible trainings for nurses. The study concluded that they were doing most EPSDT screening tasks that were appropriate for nursed to do. Therefore, no subsequent legislation followed this study.

The OSHHR was also mandated to establish a task force to facilitate communication and cooperation on blood-lead testing issues. This task force identified numerous providers that were processing pediatric blood lead tests through the state's Division of Consolidated Laboratory Services (DCLS). The state lab should only be used to process blood lead tests for children with no health insurance. Recommendations from this task force included a provider communication plan and a proper procedure matrix for the processing of blood lead tests for different payor categories.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with partners to increase enrollment in state sponsored health insurance programs.				X
2. Participate in initiatives and coalitions aimed at increasing utilization of				X

care.				
3. Fund local health districts for outreach and enrollment activities.	X			
4. Promote Bright Futures to increase access to preventive health care for children and adolescents.				X
5. Encourage school nurses to use Bright Futures materials to promote EPSDT screenings to parents.			X	
6. Develop and maintain web-based continuing education training modules, based on Bright Futures, to promote EPSDT screens in partnership with VA Chapter AAP and Department of Medical Assistance Services (state Medicaid agency).				X
7. Collaborate with the Departments of Social Services and Medical Assistance Services to develop standard training modules based on Bright Futures Mental Health to identify and refer children with mental health concerns.				X
8.				
9.				
10.				

b. Current Activities

DCAH, DWIH, DMAS, the Virginia Chapter of the American Academy of Pediatrics (AAP), and the medical education department of Virginia Commonwealth University are developing a web-based training program for health care providers to use Bright Futures to improve the quality of well-child care and to promote EPDST screenings, particularly for school age children and adolescents.

The Lead-Safe Virginia Program continues to collaborate with DMAS on issues relating to pediatric lead testing and other EPSDT program services. A data match of pediatric blood lead tests results and Medicaid recipients continues to allow DMAS to notify primary care providers of the patients that had elevated blood lead levels. This helps to ensure proper follow-up and case management. Staff of VDH and DMAS are also actively involved in instituting the proper procedure matrix for the processing of blood lead tests as recommended by the aforementioned study resolution. The message that is being communicated to providers consists of informing them that the use of DCLS processing services for insured children can jeopardize the ability of this lab to process blood lead tests for uninsured children in the Commonwealth.

In addition, VDH and DMAS continue to collaborate with the Department of Social Services (DSS) to examine data related to EPSDT services delivered to foster care children. The initiative involves supplying DSS with EPSDT services history for each foster child thereby enabling the caseworker to follow-up on the administration of preventative services for this vulnerable population. While the initiative slowed due to staff changes, members of the Joint Subcommittee Studying Lead Poisoning Prevention support the continuation of this effort once new staff are hired.

c. Plan for the Coming Year

The Title V DMAS liaison will continue facilitation of efforts to populate EPSDT screening frequencies into the DSS case worker database to help improve EPSDT screenings among foster care children.

VDH staff will also assist DMAS in the development of parental notification cards concerning EPSDT program services. The pilot will begin with parental reminder cards for Medicaid

recipients who did not receive a blood lead test at 12 and 24 months of age. These reminder cards will be generated in conjunction with birthday reminder cards that alert parents to the need for reenrollment in the Medicaid program.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.5	1.4	1.4	1.3	1.3
Annual Indicator	1.6	1.7	1.7	1.6	
Numerator	1618	1650	1653	1624	
Denominator	98864	98531	99235	100561	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.3	1.3	1.3	1.3	1.3

Notes - 2002

The data source is Virginia Center for Health Statistics. The 2002 birth data will be available at the beginning of 2004.

Notes - 2003

The 2003 birth data is not yet available from VA center for health statistics

Notes - 2004

2004 data not available. . .

a. Last Year's Accomplishments

Providing early and adequate prenatal care and preventing unwanted pregnancies can play a role in preventing low weight births. Local health departments served approximately 17,346 maternity patients in CY 04.

The Virginia Healthy Start Initiative (VHSI) program provided case management services to 845 high-risk pregnant minority women, postpartum and interconceptual women, and infants in four communities (Norfolk, Portsmouth, Petersburg and Westmoreland County) with high rates of low birth weights and infant mortality. In FY 04, 0.7 percent of infants born to VHSI clients were very low birth weight, which was an improvement from the previous year (1.6 percent).

Southwest Virginia Regional Perinatal Council (RPC 1) continued to implement a smoking cessation program, "Breath Easy Baby!" in an effort to reduce low weight births. Women are enrolled during their pregnancy and encouraged to remain smoke-free postpartum. The December 2003 report stated that 593 women were screened, 417 were enrolled, and 169 quit smoking.

The Northern Virginia Perinatal Council (RPC 5) negotiated with more than 30 large corporations to begin a workplace health program for pregnant women to increase the awareness of preterm labor signs and symptoms.

Eastern Virginia Perinatal Council (RPC 7) staff used their annual needs assessment to determine the training needs of providers related to low birth weights. They sponsored an annual conference on low birth weights and conducted reviews on every low birth weight case in the region.

In a new partnership, a case management course was designed for health department staff, BabyCare nurses, and social workers by VDH staff and Virginia Commonwealth University. Modules were presented in five regional workshops to improve case management skills and the quality of service.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide prenatal care through local health departments.	X			
2. Provide case management services to high-risk pregnant women.		X		
3. Educate health care providers on factors associated with poor outcomes.		X		
4. Provide smoking cessation programs.		X		
5. Conduct fetal infant mortality reviews.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

All of the perinatal councils offer training to providers in relation to reducing low weight and preterm births. The RPCs are working to reduce low weight births and very low weight births by using the fetal infant mortality review (FIMR) process to identify recommendations that can be implemented to increase the referral process with local hospitals, health departments, OB offices, and regional agencies to the appropriate level of care. All RPCs are tracking the number of very low birth weight, fetal, and infant deaths for their region and assessing the appropriateness of care in their region's health care facilities. VHSI continues case management, perinatal depression screening, and health education interventions.

Division staff served on several committees of the March of Dimes (MOD) working on the prevention of prematurity campaign and provided comments on the draft report published on preterm births in Virginia.

c. Plan for the Coming Year

Some local health departments and RPCs will focus their efforts on reducing low weight births by providing pregnant women with early entry into care and adequate care, and promoting good nutrition and increased physical activity.

Resource Mothers (RM) and BabyCare staff will continue to receive information and training on substance abuse, depression, and domestic violence that may play a role in preventing low weight births. Likewise, Healthy Start will continue its efforts to reduce low weight births and deaths.

VDH staff developed training on advanced case management and repeated the one-day basic class for those who missed it last year. A case management manual will be printed and distributed to VDH district staff.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	9.8	9.2	8.6	5.8	5.8
Annual Indicator	9.5	7.6	5.8	7.7	
Numerator	46	37	29	39	
Denominator	484065	484065	499862	508355	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	5.4	5.4	5.2	5.2

Notes - 2002

The data source is Virginia Center for Health Statistics. The 2002 mortality data will be available at the beginning of 2004

Notes - 2003

The 2003 injury death data file is not yet available from VA center for health statistics.

Notes - 2004

2004 data not available. . .

a. Last Year's Accomplishments

The Center for Injury and Violence Prevention's suicide prevention initiative is funded by the state legislature, as well as a three-year targeted injury grant from the Center's for Disease Control and Prevention. State funding was used to support a radio public awareness campaign that was conducted throughout the state in May 2004. The campaign targeted teens encouraging them to seek help if they or someone they knew were having thoughts of suicide by using the 1-800-SUICIDE national hotline. State funding was also used to develop and distribute specialized suicide prevention brochures and other print materials for parents, teachers, and teens. Additionally, grants were provided to the five suicide crisis centers to

coordinate local suicide prevention activities based on specific needs within the community. The CDC Targeted Injury Grant has made possible the following:

·Additional contracts with the crisis centers to support suicide hotlines, printing, and distribution of wallet cards listing the suicide warning signs and the 1-800-SUICIDE number, prevention billboards, region-specific radio ads and the like.
·Completion of over 450 Question, Persuade, Refer (QPR) suicide warning signs educational sessions totaling more than 4,000 individuals including middle and secondary school personnel, EMS/Fire & Rescue staff, police, and social services personnel.
·Completion of 72 Applied Suicide Intervention Skills Training (ASIST) sessions with over 2,000 participants providing great skill in identification and assessment of risk for those who may be suicidal.
·Of the 136 school divisions in the state, nearly 93 percent have had one or both of the prevention trainings for their faculty and staff.
·Over half of the state's ASIST trainers have become re-certified in the newly released Version X of the ASIST Suicide Prevention Training Model.
·ASIST trainers completed fifteen suicide prevention sessions using the new ASIST version within the first six months of receiving the re-certification.
·Nearly 400 additional Department of Corrections Education and over 200 EMS personnel received gatekeeper training last year.
·VDH led a collaborative effort to develop a Suicide Across the Lifespan Plan based on the National Strategy for Suicide Prevention.
·VDH distributed 125,000 suicide prevention brochures and 6,000 copies of the State Board of Education Suicide Prevention Guidelines to school personnel and other organizations requesting them.
·QPR sessions were presented at ten state conferences, which included those for school superintendents, emergency medical services personnel, correctional education personnel, school guidance counselors, and middle/secondary school principals.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Gatekeeper training for middle and high school youth.				X
2. Radio-based teen public awareness campaign.		X		
3. School guidelines dissemination.		X		
4. Public and provider information dissemination.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CIVP continues to provide gatekeeper training in the form of QPR and ASIST suicide prevention models. State funds will be used to contract with the local crisis centers to provide services that have been identified as region-specific suicide prevention activities (e.g. continued distribution of the suicide prevention brochures, wallet cards and other print material promoting the new 1-800-273-TALK National Suicide Prevention Lifeline, Regional Suicide

Prevention Public Awareness events, etc.). The www.preventsuicideva.org web site will continue to be utilized to provide information and resources to the general public and the suicide prevention trainers list server to share information and keep trainers current on research and trends relative to suicide prevention. An additional 12,000 individuals will be trained in the ASIST and /or QPR suicide prevention models. CIVP will continue the statewide radio broadcasts of the teen suicide prevention spots in May 2005 utilizing state funds and again in September 2005 utilizing federal funds.

A contract with the Curry School of Education at the University of Virginia will continue beyond the federal grant cycle to allow for more in-depth follow-up with training participants to determine the effect of the training on case management and collaboration with other professionals and agencies as it relates to suicide intervention in public schools. An additional 20-25 individuals will be certified to be QPR trainers to meet demand for training. CIVP will conduct QPR trainings and suicide prevention exhibits at statewide conferences for EMS, Department of Corrections Education, Public School, Parks and Recreation, Parole and Probation personnel, and other interested groups. An additional 6,000 copies of the State Board of Education Suicide Prevention Guidelines will be printed and disseminated. CIVP will continue to broaden the scope of developing community suicide prevention coalitions and continue to serve in an advisory capacity to those coalitions already started in Culpeper, Bedford, Lynchburg, and Roanoke Counties of Virginia. CIVP will provide QPR, ASIST, and Second Step Trainings for the Department of Education's annual Health for Success Conference at Longwood University and the Physical Activity Institute at James Madison University.

c. Plan for the Coming Year

Provision of gatekeeper training will be the primary focus of prevention activities beyond the life of the grant. VDH, in an effort to sustain prevention activities into the future, is working with the local crisis centers and other community groups to make sure that localities have their own certified trainers who can continue the efforts well into the future. As mentioned above, VDH will host a QPR Training for Trainers in the spring of 2005, drawing potential trainers from across the state who, once certified, can conduct local trainings. Additionally, VDH is working with local communities to develop prevention coalitions that draw from local resources to develop and maintain prevention activities that they literally create and "own". With these efforts in place, the state will serve in a coordination/advisory role while providing training materials to support the local trainers in their efforts.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	87	89	90	90	90
Annual Indicator	86.6	85.4	85.8	87.9	
Numerator	1401	1362	1418	1301	

Denominator	1618	1595	1653	1480	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	91	91	91	91

Notes - 2002

The data source is Virginia Center for Health Statistics. The 2002 birth data will be available at the beginning of 2004.

Notes - 2003

Only births with a valid facility ID were included in the denominator. Level III status is self designated; we do not have a standard statewide list of level III facilities. Current facility list derived from regional perinatal councils and VDH Center for Quality Health Care Services and Consumer Protection.

Notes - 2004

2004 data not available.

a. Last Year's Accomplishments

Blue Ridge (RPC 2) continued to monitor the neonatal transport acuity scores and report findings and recommendations annually to the hospitals in their region. They noted this model has been successful in increasing the number of very low birth weight births at a level III hospital, as 96 percent of very low birth weight births occurred there.

South Central Perinatal Council (RPC 3) and RPC 2 continued maternal/newborn transport reviews and provided FIMR findings and recommendations at each meeting with the participating hospitals. These RPCs increased the number of obstetrical providers who distribute preterm labor cards and MOD brochures to their clients.

Skyline Region Perinatal Council (RPC 4) conducted maternal/newborn transport reviews in the five hospitals for this region. RPC staff provided literature/research and professional recommendations at each transport review meeting with the participating hospitals.

VHSI continued the FIMR program in its four communities. Data from FIMR and Healthy Start clients was shared with the regional perinatal councils (RPCs) in order to examine existing infrastructure and barriers to health services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct newborn/maternal transport reviews.				**X**
2. Conduct fetal infant mortality reviews.				**X**
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

RPCs 1 and 2 are continuing to offer the Perinatal Continuing Education Program and STABLE, a course on stabilizing and transporting neonates to newborn intensive care. A component of this course involves using the case studies to identify ways to increase maternal transport versus relying on neonatal transport.

All RPCs are working to increase the number of obstetrical providers who provide preterm labor materials to their clients by distributing preterm labor cards and MOD brochures to the providers to give to their clients; RPC 5 focuses on Spanish-speaking women.

Resource Mothers (RM) and VHSI staff are reviewing data on client outcomes so that interventions can be initiated to improve the care of pregnant women.

c. Plan for the Coming Year

The RPCs will continue maternal/newborn transport reviews and provide recommendations based on the reviews at each meeting with participating hospitals. They will continue FIMRs and implement recommendations that are provided by the case review team through their consortium. The will also implement community-based initiatives, e.g., increasing the number of obstetrical providers who distribute preterm labor cards and MOD brochures to their clients. RPC 1 will develop a resource notebook for women to use during prenatal care visits with their OB/Gyn.

RPC 2 will maintain the proportion of very low birth weight infants born at level III hospitals in the Blue Ridge region by completing annual maternal/newborn transport reviews, review findings, and recommendations with the hospitals participating in the reviews.

RPC 3 will establish a Perinatal Substance Abuse Task Force to continue regional education on perinatal substance use and available services during FY 05.

RPC 5 will address the FIMR recommendation to improve perinatal loss identification and support by obstetrician's office staff. The RPC will develop a plan with the Subspecialty Center's Perinatal Loss Committee for physician and staff notification following an infant death, as well as providing a class for medical staff.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance	86	87	88	89	90

Objective					
Annual Indicator	84.6	84.9	84.7	84.8	
Numerator	83633	83619	84085	85259	
Denominator	98864	98531	99235	100561	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	91	91	91	91

Notes - 2002

The data source is Virginia Center for Health Statistics. The 2002 birth data will be available at the beginning of 2004.

Notes - 2003

The 2003 birth data is not yet available from VA center for health statistics.

Notes - 2004

2004 data not available.

a. Last Year's Accomplishments

DWIH finalized the update of the maternity guidelines for use in health department prenatal clinics and distributed the guidelines during FY 2003-2004. Sixty-nine percent of local health districts provided prenatal care in some form.

RPC 1 certified childbirth educators to provide prenatal education in all seven hospitals in this region. Resource Mothers in two regions became certified as Healthy People Healthy Babies instructors.

RPC 7 completed a Barriers-to-Care report that surveyed fifty women who did not receive prenatal care during their pregnancy. The identified barriers to care will be shared with various community organizations so that they can strategize about ways to reduce them.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Identify barriers to early entry into care by tracking pregnancies through the system.				**X**
2. Operate an incentive program to increase the number of women that obtain care in the first trimester.		**X**		
3. Offer workplace education on the importance of prenatal care.		**X**		
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

Staff in local health departments and the RM and VHSI programs conduct outreach to get pregnant women into prenatal care in the first trimester. In addition, the RM and VHSI programs participate in collaborative planning to increase the assessment of pregnant women for substance abuse and perinatal depression. Staff develop private provider skills through training to serve low-income pregnant women and facilitate access to medical insurance and community resources.

RPC 1 is certifying six more childbirth educators by targeting the Comprehensive Health Investment Project (CHIP), RM, hospitals, obstetrical offices, and health departments.

RPC 2 is collaborating with the Henry County/Martinsville Health Department to track women with a positive pregnancy test until they are enrolled in prenatal care. The RPC will analyze and provide a report on the data. RPC 2 is also implementing the Community Voices project with lay health advisors to educate women about the importance of seeking early and adequate prenatal care.

RPC 3 is continuing the Beds and Britches Program, a prenatal care incentive project that encourages early prenatal care.

RPC 7 staff are helping VHSI staff increase the number of women they serve. In Norfolk, the goal is to serve 75 clients, and in Portsmouth the goal is to serve 40 clients.

c. Plan for the Coming Year

RPC 1 will be offering the Healthy Pregnancy Healthy Baby instructors course to certify 18 additional childbirth educators in the Southwest region by 2008.

RPC 2 will continue collaborating with a health department and with For the Children -- a nonprofit organization aimed at reducing risky behavior and assisting people with making positive choices -- to increase community awareness on the disparities of African-American infant morbidity and mortality and the importance of early and adequate prenatal care. They will also implement a Community Voices program.

RPC 3 will increase the proportion of lay health advisors who understand the importance of early and adequate prenatal care so that they can educate their patients and maintain the Beds & Britches prenatal care incentive program.

RPC 7 will increase awareness of regional home visiting programs, perinatal services providers, and agencies offering services to the perinatal patients and their families by maintaining the enrollment of women in the Norfolk and Portsmouth VHSI programs. The RPC plans to continue to partner with the Consortium for Infant and Child Health to support perinatal health in urban housing developments by providing training to the community ambassadors.

D. STATE PERFORMANCE MEASURES

State Performance Measure 2: *The percent of children and adolescents who have a specific source of ongoing primary care for coordination of their preventive and episodic health care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	82	80	80	84
Annual Indicator	75	75	75	75	
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84	84	84	84	

Notes - 2002

2002 data is not available. The data will be updated when SLAITS module is released.

Notes - 2003

2002 Data are not available yet. Data cited from 2001 Virginia Children's Health Access Survey. Future data will be used from National Survey of Children's Health.

Notes - 2004

2004 data not available

a. Last Year's Accomplishments

As referenced in NPM #13, VDH received an Early Childhood Comprehensive Systems (ECCS) Grant. One of the primary areas of focus required in this initiative is promotion of medical homes for the early childhood population. The Virginia ECCS grant worked on completing the required environmental scan. A survey was conducted among early childhood serving agencies and organizations. Questions addressed current activities and gaps regarding children's access to a medical home. Data will be used to help drive future activities, including those supported by Title V, to promote access to and use of medical homes. Throughout the Virginia ECCS strategic planning process (from planning to implementation), the Title V program has partnered where possible to improve systems of care and medical homes for the early childhood population. One of the outcomes for the ECCS grant is a state strategic plan. Focus areas in the Virginia state strategic plan attempt to address gaps identified in the initial analysis of the environmental scan and embrace the following: 1) a universal understanding and acceptance of a medical home, 2) financial means of providing health coverage, and 3) accessibility to services.

In FY 04, Title V funds supported the Comprehensive Health Investment Project (CHIP) case management program in the Roanoke health district. The CHIP program provided medical/social case management for low-income families with children aged 0 to 6 years. Both CHIP and Resource Mothers are Title V enabling services that ensure children have a primary care provider. In FY 04, Title V supported outreach efforts to identify medical homes in Alexandria, Chesterfield, Cumberland Plateau, Hampton, Lord Fairfax, Richmond, and Virginia Beach. Title V supported comprehensive primary care services in Norfolk, Hampton, and Alexandria.

Resource Mothers and DCAH staff collaborated on the New Parent Kit described in NPM #7. Home visiting groups such as CHIP of Virginia, Healthy Families, and Resource Mothers developed coordination plans for local distribution efforts to provide all new parents in the state with a kit. Pilots in Southwest and Tidewater regions were conducted in 2004. Over 70 percent of new parents in the targeted areas received a kit. The kit provided these parents with information about choosing and using a pediatrician, as well as information about obtaining health insurance and accessing additional health resources. Title V representatives continued serving on several groups whose mission includes increasing access to care and medical homes. These have been referenced in discussions of NPMs #13 and #14.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Fund local health districts to assist families in finding and utilizing a medical home.		X		X
2. Participate in initiatives and coalitions that aim to increase utilization of medical homes.				X
3. Continue surveillance, monitoring, and dissemination of data related to utilization of care.				X
4. Work with the AAP to promote the medical home concept for all children and adolescents.				X
5. Work with school nurses to promote the medical home concept to school children and their parents.				X
6. Collaborate with state Early Childhood Comprehensive Systems Project to implement a strategic plan for assurance of medical and dental homes.				X
7.				
8.				
9.				
10.				

b. Current Activities

As referenced in NPM # 13, VDH OFHS is in their second year of a SECCS planning grant from MCHB. As part of the environmental scan, VECCS is assessing barriers related to obtaining medical homes, utilization of care systems, and other systems issues. Under the ECCS framework, partnerships are being explored which could improve capacity and processes to ensure medical homes for young children. The medical home work group will complete the state strategic plan late spring. Implementation of the plan will begin summer/fall 2005. Title V-supported MCH staff continue to collaborate on these efforts.

In FY 05, VDH is funding health district activities that promote access to medical homes. Alexandria, Chesterfield, Cumberland Plateau, Norfolk, Richmond City, Roanoke City, and Virginia Beach are among those districts conducting primary care clinics, case management, public education, and/or outreach to enroll children in health insurance.

Title V representatives continue serving on multidisciplinary groups such as the Covering Kids and Families (CKF) Task Force on Values, Access, and Utilization of Services. In addition, VDH continues collaborating with the Virginia Chapter of Academy of Pediatrics to promote the

concept of medical home and working with the Virginia Academy of Family Practice to promote this concept in practice. These groups have continued partnerships and promoting messages regarding the importance of preventive care, increased ability to navigate systems of care, and monitoring use of services. As Virginia has experienced measurable success in increasing enrollment into public health insurance programs, the focus of these groups has moved towards a greater emphasis on access and use of medical services, including promotion of medical homes.

c. Plan for the Coming Year

Staff will continue to participate in the partnerships described under current activities. Training on medical home will continue. The VDH data system used by local health districts has been enhanced to support applications for Medicaid and SCHIP programs, and eight health districts have been awarded Title V funds to support local efforts to link children with medical homes.

State Performance Measure 6: *The unintentional injury hospitalization rate for children 1-14 per 100,000*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	167.5	145	142.5	140	137.5
Annual Indicator	147.8	142.7	114.4	117.8	
Numerator	2011	1941	1580	1646	
Denominator	1360313	1360313	1381105	1397075	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	135	132.5	130	130	130

Notes - 2002

The data source is Virginia Health Information (VHI). The 2002 hospital discharges data will be available at the beginning of 2004

Notes - 2003

The 2003 Virginia hospital discharge data is not yet available.

Notes - 2004

2004 data not available. . .

a. Last Year's Accomplishments

The Center for Injury and Violence Prevention (CIVP) resource center supported hundreds of community groups with educational materials for their injury prevention projects. Title V funds supported the development of a web-based online injury data reporting system that enables

users to access injury related death and hospitalization data from 1998 and to analyze this data by age, race, sex, location, mechanism and intent of injury. The database is currently going through modification and is anticipated to be ready for widespread promotion and use by May 2005. CIVP continued to implement full integration of bike training and helmet promotion programs into the Health and Physical Education Curriculum in three schools, and supported thirty-six community helmet promotion projects with mini-grants. The Center coordinated a statewide holiday bicycle helmet distribution and education project in conjunction with Virginia's Salvation Army and Sergeant Santa toy drive programs. CIVP was also a sponsor of an internationally recognized professional cycling event, CapTech Classic, which provided the opportunity to promote the message of bicycle and helmet safety to hundreds of spectators and distribute and properly fit bicycle helmets to 300 inner-city children observing the event.

CIVP translated pedestrian safety information contained in the pedestrian safety tool kit into Spanish to enable these efforts to reach additional populations. Staff disseminated playground safety information to targeted audiences statewide during playground safety week in April. CIVP developed a safety fair planning kit to assist elementary and middle school aged children in learning about injury prevention and then educating peers on the issue. The Center is coordinating annual statewide educational observance of bike safety month to encourage school and community-based safety activities. CIVP provided three regional playground safety trainings for school and parks and recreation staff based on the SAFE model, which addresses supervision, age appropriate developmental design, falls to the surface, and equipment and surface maintenance. In addition, CIVP staff managed approximately twenty fire and gun injury prevention programs and educated a variety of stakeholders with presentations on injury prevention. The New Parent Kit contains safety information on prevention of unintentional injuries and was distributed statewide to all new parents in the Commonwealth. The Center continued to produce and distribute statewide via mailings and electronically the Injury Prevention Newsletter highlighting new resources, programs, information, and trainings in the injury prevention field. CIVP also developed infant safe sleep tip cards for distribution in the Injury Prevention Resource Center.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Radio-based public awareness campaigns.		X		
2. Community injury prevention project support.		X		
3. Public education material dissemination.		X		
4. Safety device dissemination (e.g. child restraints, gun locks, smoke alarms).		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Center for Injury and Violence Prevention's epidemiologist produced and disseminated a report on death and hospitalization data for 2003. Title V funds supported CIVP in providing oversight to staff that manage community childhood injury prevention projects. CIVP is working

to ensure that injury prevention projects are effective and focused on the relevant mechanisms of injury. CIVP staff analyzed hospitalization data from 1998-2003 and death data from 1999-2003 for Virginias under the age of twenty. The top four mechanisms of injury related hospitalization and death were selected to be the focus areas to be addressed during FY05. CIVP will focus its injury prevention efforts for the identified mechanisms in the following three areas:

1. CIVP is improving injury prevention through school settings. The framework that the Injury Prevention Program is using for school-based injury prevention activities is the American Academy of Pediatrics' School Health, Mental Health and Safety Guidelines and the CDC School Health Index.
2. CIVP is improving injury prevention through community settings. The IPP is establishing or strengthening partnerships with those groups that currently work in communities and have established networking capabilities. The groups that IPP will primarily partner with are the Virginia SAFE KIDS coalitions, the Virginia Association of Fire & Life Safety Educators, Virginia EMS for Children Program, and the regional network of Community Health Workers.
3. CIVP is expanding the use of technology (i.e. list serve, CIVP web site, web seminars, other internet resources) as a resource for injury prevention in Virginia.

CIVP is implementing full integration of bike training and helmet promotion programs into the Health and Physical Education Curriculum in thirteen schools. CIVP coordinated another statewide holiday bicycle helmet distribution program and education project for low-income children and will be coordinating the CapTech Classic bicycle helmet project. CIVP is revising a playground safety resource manual to include updated information that will be in a downloadable form on the web site and distributed to target audiences (e.g. elementary schools, parks and recreation centers, day care facilities). CIVP will conduct an Infant and Toddler Safety media campaign targeted at parents and other caregivers to prevent injuries that occur to children in these age groups in and around the home due to lack of supervision. This campaign will consist of a series of public service announcements that will be aired on the radio statewide addressing some of the leading causes of injury related hospitalizations and deaths to infants and toddlers. The first series of the issues discussed will cover drowning, suffocation, and leaving children unattended in vehicles.

c. Plan for the Coming Year

CIVP plans to continue to provide training and consultation on injury prevention data and strategies, share prevention education resources through active use of technology and other means, disseminate safety devices (e.g. bike helmets, smoke alarms, gun locks), and support community injury prevention projects. CIVP will be actively promoting injury and violence prevention guidelines and resources for elementary, middle, and high schools. CIVP plans to host a Consumer Product Safety Commission workshop on injury prevention areas as identified by the current injury data.

This state performance measure will not be continued. The unintentional injury death rate for ages 1-14 will become a new State Outcome measure. CIVP's activities to address unintentional injuries and deaths will continue.

State Performance Measure 7: *The incidence of assault injuries hospitalizations among people aged 10-19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	23.5	21.0	20	19	18
Annual Indicator	21.1	21.5	18.4	22.7	
Numerator	207	211	187	234	
Denominator	980020	980020	1014635	1028914	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17	16	15	15	15

Notes - 2002

The data source is Virginia Health Information (VHI). The 2002 hospital discharges data will be available at the beginning of 2004

Notes - 2003

The 2003 Virginia hospital discharge data is not yet available.

Notes - 2004

2004 data not available. . .

a. Last Year's Accomplishments

In conjunction with the Safe and Drug Free Schools program at the Department of Education and the School Safety Center at the Department of Criminal Justice Services, VDH coordinated an annual resource dissemination of parent-targeted violence prevention education materials for back to school events. VDH also promoted a web site, Best Practices for Youth Violence Prevention, which was developed in conjunction with the Department of Education and Virginia Commonwealth University, Center for the Study and Prevention of Youth Violence. The web site enables educators to research all of the programs that meet national standards and to identify the program that best meets the needs and goals of their community audience. VDH provided training based on the best practice model of Second Step. VDH adapted a youth violence prevention manual and screening and referral cards for child and adolescent health providers. One set of the materials was initially provided to 3,000 health providers; an additional 4,000 cards and 1,000 manuals were provided upon request.

VDH Title V staff produced a report, Child Sexual Assault Victimization in Virginia, and supervised over 50 trainings that were held for youth service providers on sexual coercion and exploitation of minor teens. Title V staff were also involved in developing a Community Speaker's Bureau which conducted 140 presentations in local communities on the importance of involving males in the issue of sexual violence prevention. As part of the CDC Rape Prevention Education program (RPE), VDH sponsored 43 presentations of the theatre production, Hugs and Kisses, a play about child sexual abuse produced in elementary schools. VDH also developed two statewide public awareness campaigns. The Men of Strength Campaign, funded through RPE, encouraged males to be respectful and nonviolent with the words, "my strength is not for hurting." The "Isn't She a Little Young" Campaign, a state funded program which received national attention, encouraged men to talk with other men about discouraging adult sex with minors. VDH provided RPE funding to eighteen local sexual assault

centers to provide sexual violence prevention programming in the local communities; many of the centers provide prevention programming targeted at middle or high school youth.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screening and counseling resource development and dissemination to health providers.		X		
2. Prevention program training and referral for schools.		X		
3. Public education material dissemination.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

VDH works to prevent violence through its programs in sexual violence, domestic violence, statutory rape and bullying. VDH received a two-year grant to improve child and adolescent health by enhancing Virginia's capacity to prevent violence. Virginia is one of eight states to receive funding from the Centers for Disease Control and Prevention for the two-year program that works to support change in societal norms and environmental conditions contributing to violence. VDH has brought together a work group to 1) prepare a state report card on risk and protective factors associated with the prevention of violence perpetrated toward or among children and adolescents and 2) identify issues and strategies that will facilitate support for sustaining and enhancing perpetration prevention activities.

VDH is supporting community-based organizations by providing funding to implement bullying prevention programs in the local communities to increase collaboration around bullying prevention, raise awareness of bullying prevention activities and reduce overall bullying in Virginia. VDH provides on-site training to each of the fifteen funded communities on bullying prevention.

VDH continues to distribute materials to health care providers on recognizing and responding to youth violence. The brochure and screening and counseling guide include screening questions and counseling tips for recognizing and preventing youth violence. VDH has reproduced the Stop Bullying Now Resource Kit developed by HRSA and is widely promoting and distributing it to communities in Virginia.

VDH Title V staff continue to be involved in the coordination of the CDC Rape Prevention Education (RPE) program that provides funding to eighteen local sexual assault centers to provide sexual assault prevention programming in the local communities. As part of the RPE program, four Child Assault Prevention trainings are planned to teach teams from local communities to present a program on child sexual abuse in the schools. An additional training is planned to teach about the role of men in sexual violence prevention. The Men of Strength Campaign is continuing.

As part of its state-funded statutory rape prevention program, which is supervised by Title V staff, VDH is continuing to provide training to the following groups: 1) youth service providers on sexual coercion and sexual exploitation of minor teens; 2) law enforcement officials on the dynamics of sexual coercion and the laws; and 3) youth to educate them about sexual coercion. VDH is working to develop a public awareness campaign targeting Latino men on the issue of statutory rape.

c. Plan for the Coming Year

VDH plans to continue to share youth violence prevention resources through the web site and targeted mailings and to collaborate with other state level partners to coordinate trainings and workshops on youth violence prevention, especially bullying prevention, for community stakeholders.

As part of the Enhancing State Capacity to Address Violence Prevention, VDH will produce and publish a strategic plan that delineates shared risk and protective factors and identifies strategies that address ecological factors that influence and prevent violence. VDH will also continue its outreach to health care providers to screen for violence and provide counseling. VDH will continue its outreach to males to work to end sexual violence. VDH will expand its child sexual assault prevention program through the implementation of the Stop It Now! helpline that allows families and friends of persons suspected of sexually abusing a child to call and receive advice. VDH is also developing a teen dating violence prevention initiative.

This state performance measure will not be included in future plans although major activities to address intentional injuries will continue.

State Performance Measure 8: *Rate of neural tube defects among live births in Virginia.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5.0	5.0	5.0	5.0	5.0
Annual Indicator	6.5	3.0	3.2	3.2	
Numerator	64	30	31		
Denominator	98864	98531	97390		
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.0	5	5	4	4

Notes - 2002

ICD9-CM Codes:
740.0-740.1

741.0
741.9
742.0

Notes - 2003

Data from Virginia Infant Tracking and Infant Screening System, Virginia CARES--birth defects registry.

Notes - 2004

2004 Data not available.

a. Last Year's Accomplishments

In FY 04, the Pediatric Screening and Genetic Services (PSGS) director continued to manage the three-year CDC-funded birth defects surveillance and prevention grant, Virginia Congenital Anomalies Tracking and Prevention Improvement Project (VaCATPIP I), which was awarded in FY 02. The VaCATPIP I time period was from March 1, 2002 through February 28, 2005. Following are two of the seven VaCATPIP I objectives that are specific to neural tube defects (NTD) prevention: (1) to involve appropriate additional partners within Virginia to expand VDH NTD-prevention activities and enhance intervention and support services for children with an NTD and (2) to evaluate VDH NTD-prevention activities.

PSGS staff, in partnership with the Virginia Council on Folic Acid (VCFA) and the Division of Dental Health, reprinted and distributed a small educational tabletop display (designed in FY 03) about the importance of folic acid and the prevention of NTDs to all WIC clinics, local health departments, community health centers, and free clinics.

In addition, the Virginia Folic Acid Campaign (VFAC) manager and the Virginia Commonwealth University-contracted genetic counselor, both of which are VaCATPIP I supported positions, implemented the following NTD-prevention activities: (1) provided leadership and support for enhancing the VCFA; (2) developed and initiated a statewide folic acid informational campaign plan to include primary and secondary prevention in coordination with key stakeholders; (3) evaluated the use of the folic acid/NTD prevention display; and (4) developed a folic acid supplement distribution program. Specific VFAC manager activities included the following: (1) implementing a televised public service announcement, conducting a radio interview, and issuing a press release to increase awareness about the use of folic acid; (2) making available a Spanish version of the folic acid/NTD prevention display; (3) composing and submitting articles about folic acid to professional journals and health care/educational organizations; (4) participating in public and professional conferences to distribute folic acid information; and (5) meeting with Care Connection for Children coordinators to reinforce the importance of discussing folic acid with their clients and distributing educational materials. Specific genetic counselor activities included (1) developing a pilot program for counseling and educating families who have a child with an NTD; (2) assessing the uptake of Part C Early Intervention services for children with spina bifida; and (3) managing the translation of VDH fact sheets on anencephaly and spina bifida into Spanish.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide leadership and support to the Virginia Council on Folic Acid, which provides ongoing educational programs to maintain awareness about the importance of the daily intake of folic acid.				X
2. Develop, implement, and evaluate a long-term birth defects prevention, multi-layer communication campaign based on epidemiologic				

and social marketing principles that targets, on a phase-in basis, NTDs, fetal alcohol spectrum disorders, and other spec			X	
3. Assure the provision of folic acid to women who have a child with a neural tube defect, as identified by Virginia's birth defects registry.	X			
4. Assure the provision of culturally competent educational materials targeted to women of childbearing age on the importance of getting 0.4 mg of folic acid every day to help prevent neural tube defects.		X		
5. Virginia Folic Acid Campaign Manager (VFACM) will continue as an active participant on the Virginia Council on Folic Acid (VCFA) to provide leadership and support.		X		
6. The genetic counselor will continue a pilot program for counseling and educating families that have a child who has a neural tube defect.		X	X	
7. The genetic counselor will continue to assess the uptake of Part C services for children with spina bifida.		X		
8. VFACM and key stakeholders will continue to develop and initiate a statewide folic acid informational campaign plan to include primary and secondary prevention.		X		
9. VFACM will assure the continued provision of folic acid to women who have a child with a neural tube defect, as identified by Virginia's birth defects registry.		X		
10. The genetic counselor will work with contractors to develop a regional genetics education program for professionals based on assessed educational needs.		X		

b. Current Activities

During FY 05, the VFAC manager carried out the following activities: (1) continued as an active participant on the VCFA, providing leadership and support for enhancing VCFA functions; and (2) in collaboration with key stakeholders, continued to develop and initiate a statewide folic acid informational campaign plan that contains primary and secondary prevention messages, which included (a) purchasing and broadcasting folic acid television advertisements in high risk communities for two weeks and (b) purchasing and distributing 113,750 bottles of 0.4 mg folic acid to VDH Family Planning Clinic clients in health districts with the highest rates of NTDs. In addition, the genetic counselor carried out the following activities: (1) continued gathering materials for counseling and educating families who have a child with an NTD and (2) worked with contractors to organize a statewide genetics conference entitled "Genetic Horizons: Integrating Genetics Into Public Health," which included NTD-prevention information. The VaCATPIP I grant ended 2/28/05, and a 12-month no-cost extension was requested to complete final year activities.

VDH was awarded a five-year CDC-funded birth defects surveillance and prevention grant to support VaCATPIP II beginning 3/1/05. The PSGS director is the VaCATPIP II project director. Following are two of the nine objectives that are specific to NTD prevention: (1) to involve appropriate additional partners within Virginia to expand NTD prevention and initiate other prevention programs based on epidemiological and social marketing principles and (2) to expand partnerships to share results and integrate genetics into public health. During FY 05, VaCATPIP II funds will support about 50 percent of the VFAC manager position. Specific VFAC manager activities include the following: (1) providing VCFA leadership and being the liaison to VaCATPIP II; (2) evaluating most effective folic acid messages for the Latino population and incorporating such messages into a birth defects prevention campaign; (3) working with family planning clinics on folic acid distribution; and (4) conducting a folic acid supplement distribution follow-up evaluation.

c. Plan for the Coming Year

During FY 06, the VFAC manager will continue to be involved in the following VaCATPIP II NTD-prevention activities: (1) enhance and expand the Virginia Folic Acid Campaign; (2) build public and private partnerships through participating on coalitions or committees, networking, and attending conferences; (3) provide leadership and support to the VCFA, including convening and facilitating meetings in collaboration with the March of Dimes, Virginia Chapter; (4) under the guidance of the PSGS director, assist in writing NTD-prevention components of the CDC cooperative agreement, including budgets, progress reports, and cooperative agreement renewals; (5) in coordination with the PSGS director, manage project-funded contracts and memorandums of agreement that involve NTD prevention; and (6) in coordination with the genetic counselor, review, update, and develop VDH NTD-prevention education materials for healthcare providers and consumers.

This state performance measure will not be included in future plans. Activities addressing the use of folic acid will continue in the coming year.

State Performance Measure 9: *Percent of children who are overweight or obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	17.4	17	17	16	15
Annual Indicator	17.4	17.4	17.4	17.4	
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14	14	14	14	

Notes - 2002

Data from fourth grade nutritional survey is not yet available for 2002.

Notes - 2003

Data from fourth grade nutritional survey is not available for 2002 or 2003.

Notes - 2004

2004 Data not available

a. Last Year's Accomplishments

The After School Curriculum Kit was evaluated by Virginia Tech in a variety of after school programs throughout Virginia.

In July and August 2004, the Division of WIC and Community Nutrition Services (DWCNS) provided training to Virginia Department of Health's 35 health districts and invitees on Addressing Childhood Overweight in Our Communities: Training for a Public Health Initiative. More than 900 participants attended this event. The training provided participants the opportunity to discuss barrier and develop strategies for addressing childhood overweight in their communities.

On September 9, 2004, DWCNS in collaboration with the State Board of Health hosted executives from public and private organizations throughout the Commonwealth at Virginia's Expanding Waistline: How it Affects the Bottomline. This briefing highlighted the medical aspects of obesity, compared and contrasted national and Virginia specific data, direct and indirect costs of obesity, and highlighted national programs and available funding. Governor Mark R. Warner issued a proclamation in support of the briefing. Jane Woods, Secretary of Health and Human Resources for the Commonwealth, closed the briefing with a call to commitment from the attendees.

DWCNS conducted a Virginia specific data search that included the mailing of 2,000 letters and phone calls in order to solicit Virginia specific data regarding obesity. DWCNS was able to obtain data from CommonHealth medical screenings of state employees, 8,000 records from Patient First medical clinics, as well as data from college student centers and several community coalitions. Future collaborative partners were identified from various organizations.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Evaluate the After School Ccurriculum Kit; adjustments will be made and the kits will be distributed.				X
2. Provide training to school staff, child care providers, and others out of home care providers on obesity prevention initiatives.			X	
3. Fund and support local health district programs that address childhood obesity.		X		
4. Participate in coalitions and collaboratives aimed at policy and program development to promote healthy nutrition and adequate physical activity.				X
5. Collaborate with the Department of Education to develop and maintain web-based health and physical activity curriculum resource consistent with Standards of Learning for health, physical education, and elementary classroom teachers.			X	
6. Support activities of Virginia Action for Healthy Kids to improve access to healthy foods and increased physical activity opportunities within schools.				X
7. Employee wellness program, "Step 'n' Up for a Healthier Virginia" was completed. The program evaluation showed that projected goals were achieved.		X		
8. "Eat Smart Virginia", an obesity prevention tool kit, is being revised and guidance for usage is being developed.				X
9. DWCNS collaborated with the Department of Education to provide materials for the Health and Physical Activity Institute and to launch a web site, "Health Smart Virginia".		X		

10. DWCNS adopted a process for the development of a statewide plan addressing the prevention and control of obesit. DWCNS is in the process of conducting six regional meetings for the Commonwealth's Healthy Approach and Mobilization Plan for Inactivity				X

b. Current Activities

The final report from the After School Curriculum Kit evaluation was received in March 2005. The kits were well received as indicated in the report with only some minor changes suggested by those after school providers that participated in the evaluation.

The Division of WIC & Community Nutrition Services completed a successful employee wellness program, Step ‘n' Up for a Healthier Virginia. This stair-climbing program was based on climbing the world's tallest buildings. The program achieved its goal and objectives. The evaluation revealed that the program encouraged employees to increase their stair usage and physical activity levels during and after work hours.

Eat Smart Virginia is a family obesity prevention tool kit designed to achieve the following goals: educate families on the risks associated with obesity; provide sound nutrition practices and principles that can be used to combat obesity; and supply techniques to increase physical activity across the life cycle. During FY 05, a segment from the faith-based community was contacted for the purpose of surveying their membership on their perception of the health and wellness of their congregations. The Eat Smart Virginia Program presents itself as an educational opportunity to affirm or reaffirm the linkages between nutrition, physical activity, and disease.

The Division of WIC & Community Nutrition Services collaborated with the Department of Education to provide materials for the July 2004 Health and Physical Activity Institute. DWCNS developed a PowerPoint presentation about healthy food choices and how to use and evaluate a Food Diary. A CD-Rom of the presentation was also provided to the participants of the institute.

Henrico County Schools decided to add Nutrition to their health curriculum in all elementary schools. DWCNS has worked with the Health and Physical Education supervisor to seek materials for teachers to use to teach nutrition. DWCNS is continuing to seek out sources of nutrition education tools to be used with elementary students.

DWCNS collaborated with the Department of Education to develop and launch the "Health Smart Virginia" web site (healthsmartva.pwnet.org). The web site is intended for use by teachers to obtain curriculum to use in health classes, information on health topics, and SOL documents.

DWCNS has adopted a process for the development of a statewide plan addressing prevention and control of obesity in Virginia. DWCNS is in the process of conducting six regional meetings for their Commonwealth's Healthy Approach and Mobilization Plan for Inactivity, Obesity and Nutrition (CHAMPION). Invitees include business, government, and faith-based organizations. CHAMPION's goals are to develop a coordinated strategic plan that addresses obesity in Virginia and to compile a statewide electronic resource guide including a directory on community programs as well as data that is relative to obesity in Virginia.

c. Plan for the Coming Year

DWCNS, with the guidance of an Advisory Committee composed of experts in the field of Public Health, will create a CHAMPION plan. This plan will showcase a statewide strategy that will help to guide VDH and the citizens of the Commonwealth in their obesity prevention efforts. The plan will be made available to Governor Mark Warner in late fall 2005. DWCNS will be

tasked with locating applicable grants both for groups at the local level, as well as the state level that support the CHAMPION plan.

DWCNS will collaborate with Virginia Healthy Communities to launch a web-enabled system that will allow local organizations to share obesity prevention program information, data, and resources with other organizations and Virginia's public. This web site will be available in the fall 2005. The site will include a searchable resource directory of physical activity and community nutrition programs and initiatives in the Commonwealth. The site will have links to available grants and educational resources.

In July 2005, DWCNS staff will provide education on obesity prevention and physical activity to Virginia school nurses at the School Health Institute and to physical education teachers at the Health and Physical Activity Institute.

In the spring of 2006, DWCNS will begin a series of regional "Addressing Childhood Overweight" meetings to further strengthen community networks that were established in 2004 with the first series of these meetings.

State Performance Measure 10: *The degree to which statewide data are available to monitor health-related behaviors among youth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	0	6	6	6	10
Annual Indicator		6	6	6	6
Numerator		6	6	6	6
Denominator	16	16	16	16	16
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	10	10	10

Notes - 2002

This measure is used to monitor the number of health-related behaviors for which statewide data are available. It is based on a 16 point scale. In 2002, the Community Youth Survey provided provisional statewide data on youth behaviors for tobacco use, alcohol use, and drug use.

a. Last Year's Accomplishments

VDH collaborated with the Department of Education to collect and report body mass index (BMI) data for students according to measurement. A BMI data field was added to the physical activity report card that is completed on each student.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor current data collection activities that measure youth health related behaviors.				X
2. Compile and disseminate any available data related to youth health related behaviors.				X
3. Identify gaps and needs for data regarding youth health related behaviors.				X
4. Collaborate with the Department of Education to collect statewide Body Mass Index (BMI) for students.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Title V program continued to explore the possibility of conducting a statewide Youth Risk Behavior Survey (YRBS) to meet some of the data needs regarding the health related behaviors. In November 2004 the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services' 2003 Virginia Community Youth Survey report was released. In addition the report from the Youth Tobacco Survey sponsored by the Virginia Tobacco Settlement Foundation was also made available. These surveys were conducted statewide and provide data related to youth substance use.

c. Plan for the Coming Year

This state performance measure will not be included in future plans. However, VDH will continue to advocate for the statewide participation in the YRBS.

State Performance Measure 11: *Percent of newborns screened for hearing loss who receive recommended follow-up services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	62	70	73	77	81
Annual Indicator	62.1	70.8	66.5	71.0	

Numerator	1987	2459	2098	2161	
Denominator	3199	3472	3156	3042	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	89	93	95	95

Notes - 2002

Data for newborns screened for hearing loss are not yet available for CY 2002.

Notes - 2003

Data are from the Virginia Early Hearing Detection and Intervention Program. Database transition occurred in May 2002 from TONE to Virginia Infant Screening and Infant Tracking System (VISITS).

Notes - 2004

2004 data not available.

a. Last Year's Accomplishments

During FY 04, the Virginia Early Hearing Detection and Intervention (VEHDI) Program carried out the following activities: (1) collaborated with the Part C Early Intervention System to track outcomes for those children with hearing loss who were referred to and received Part C services; (2) conducted Sensory Kids Impaired- Home Intervention (SKI-HI) training for early intervention providers on support and resources in natural environments for families with infants, toddlers, and preschoolers (age birth to five years) who are deaf and hard of hearing; (3) established an enhanced voice mail system for the toll-free line, translated into four languages other than English; (4) enhanced the VISITS Hearing Module to allow documentation of tracking and follow-up activities as well as patient outcomes; and (5) hired a follow-up coordinator fluent in English and Spanish to increase capacity to follow-up on the growing Hispanic population.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Administer statewide early hearing detection and intervention program.			**X**	
2. Mail letters to parents and primary care providers regarding screening results and follow-up.	**X**			
3. Implement aggressive tracking activities for childen lost to follow-up.	**X**			
4. Collaborate with Part C Early Intervention System to streamline referrals and document outcomes.				**X**
5. Provide parent to parent contact for families of children with hearing loss.		**X**		
6.				
7.				
8.				
9.				

10.					

b. Current Activities

In FY 05, the VEHDI Program carried out the following activities: (1) continued training efforts for audiologists and primary medical care providers with a focus on hands-on, skills-building for audiologists and replication of the American Academy of Pediatrics teleconferences held last year; (2) initiated the establishment of a hearing aid loaner bank for infants and young children (3 years of age and under) that will be available when the child is first diagnosed; (3) disseminated the Parent Resource Guide video that was created in FY 04 to audiologists and early intervention programs statewide; (4) collaborated with the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Service (the lead agency for Part C) and the Virginia Department of Education to establish a system for collecting outcome data for children with hearing loss across agencies; and (5) distributed a video (produced by National Center for Hearing Assessment and Management) that explains the newborn hearing screening process to parents all birthing hospitals. Furthermore, VEHDI Program staff members submitted a grant application to HRSA for funds to support follow-up efforts and participated in writing the five-year CDC-funded birth defects surveillance and prevention grant (began 3/1/05) to support VaCATPIP II. The project's EHDI follow-up activities include ensuring that the VISITS /Early Intervention Referral System is fully operational statewide.

c. Plan for the Coming Year

During FY 06, the VEHDI Program will add a part-time staff person to assist with follow-up activities, including tracking of children lost to follow-up. Staff will update the resources section of the Parent Resource Guide, continue with training and education activities for PCP, audiologists, and early intervention providers, and conduct a survey of parents. The VEHDI Program will continue to maintain the hearing aid loaner bank. In addition, staff will continue collaboration with Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Service and the Virginia Department of Education to establish a system for collecting and sharing outcome data for children with hearing loss across agencies.

State Performance Measure 12: *The percentage of women in Virginia's perinatal underserved areas receiving adequate prenatal care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75.0	76.7	77	77.5	78
Annual Indicator	75.8	88.7	88.6	90.3	
Numerator	15914	15731	15860	17635	
Denominator	20987	17744	17906	19534	
Is the Data Provisional or Final?				Final	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	78.5	79	80	80	92

Notes - 2002

Data Source: 2001 Virginia Health Statistics. 2002 data are not available. This performance measure has not proven to be an accurate indicator of adequate prenatal care. It is tied to utilization rates in localities included in the Perinatal Underserved Report that has only been updated once and will not be updated again due to lack of use. Thus, this performance measure will be discontinued in future years.

Notes - 2003

Notes - 2004

2004 data not available.

a. Last Year's Accomplishments

The RPC, RM and VHSI programs and local health districts continued working to increase the number of women receiving adequate prenatal care in underserved areas. In addition, the Division of Women's and Infants' Health played a major role in completing a Governor's report that addressed this problem. A description can be found in the Other Activities section.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Start and Resource Mothers encourage adequate care through outreach and education.		X		
2. Case management for high-risk pregnant women.		X	X	
3. Identify/reduce barriers to prenatal care in order to maintain pregnancies.		X		
4. Publicizing findings on barriers to care to increase communication between providers.		X		
5. Promote workplace health programs.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The RPCs will continue a variety of activities. RPC 1 is certifying six more childbirth educators from CHIP, Resource Mothers, hospitals, obstetric offices, and health departments.

RPC 2 is collaborating with For the Children to increase community awareness on the disparities of African-American infant mortality and morbidity and the importance of early and adequate prenatal care.

RPCs 2 and 3 will begin a Community Voices program to train community workers to encourage women to seek early prenatal care. RPC 3 has a Community Voices program that

addresses the African American infant mortality through a lay health advisor system called "Each One, Teach One." Community residents are trained in basic perinatal health, which they then share with their family, friends, churches, workplaces, and social/civic organizations. This curriculum places great emphasis on the risks of preterm labor and low birth weight for African Americans. The South Central Perinatal Council Community Voices program has already trained over 100 lay health advisors in the community. The council continues "Babies are Everybody's Business," which offers perinatal health education to consumers at their work places.

The RPC 4 consortium will support the implementation of Community Voices by providing education, statistics, and letters of support as needed to community leaders applying for the grant.

c. Plan for the Coming Year

DWIH use the Perinatal Periods of Risk methodology in the Norfolk, Richmond, and Northern Virginia areas to examine birth outcomes in more detail. This information will then be shared with the appropriate RPCs and health district leadership to discuss possible strategies. The division will also work collaboratively with DMAS, managed care organizations, VDSS, and DMHMRSAS to increase access to quality care for women and infants.

All RPCs will continue to provide education in support of the folic acid and prematurity campaigns of the March of Dimes. They will work closely with the community service board in their region to ensure clients obtain substance use and mental health services.

DWIH may be playing a role in supporting the pilot program for certified nurse midwives to work in underserved areas (described in the Other Activities section).

This state performance measure will be changed to address the adequacy of prenatal care statewide rather than just areas with low utilization rates.

State Performance Measure 13: *The percentage of low birth weight births to African Americans in nine underserved areas.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	12.3	13.3	13.1	12.9	12.7
Annual Indicator	12.8	12.2	12.7	13.3	
Numerator	626	605	615	636	
Denominator	4907	4978	4849	4787	
Is the Data Provisional or Final?				Final	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	12.5	12.3	12.1	11.9	11.7

Notes - 2002

The data source is Virginia Center for Health Statistics. The 2002 birth data will be available at the beginning of 2004.

Notes - 2003

No data available for 2003 until this summer.

Notes - 2004

2004 data not available. . .

a. Last Year's Accomplishments

DWIH continued to provide VHSI case management services and health education to African American women in four local communities (Norfolk, Portsmouth, Petersburg, and Westmoreland County.) VHSI staff served 845 pregnant, postpartum, and interconceptual women and infants last year, of which 75 percent were African American.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Smoking cessation programs.		X		
2. Community outreach and education to encourage early entry into care.		X		
3. Using perinatal periods of risk approach in two cities.				X
4. Preconception education, e.g., folic acid.		X		
5. Collaborating with March of Dimes on prematurity campaign.		X		
6. Case management of pregnant women.		X		
7. Increase awareness of and participation in Healthy Start.		X		
8.				
9.				
10.				

b. Current Activities

VHSI is conducting outreach to facilitate pregnant women's entry into early prenatal care. The program continues to provide case management, medical nutrition therapy, and health education services, and assessments for substance abuse and perinatal depression. Staff continue activities aimed at encouraging pregnant women to stop smoking or taking drugs. Data is being reviewed to examine outcomes and to modify the program to increase effectiveness. Preconception education, including nutrition counseling, is provided.

VHSI completed evaluation of data to determine if the Perinatal Periods of Risk (PPOR) approach could be used to evaluate the communities served by this program. The communities of Portsmouth and Norfolk within the Virginia Healthy Start Program meet data criteria for PPOR and analysis will be done in FY 06.

RPC 6 is working on developing a safe sleeping for babies message for the African American community.

c. Plan for the Coming Year

Healthy Start will continue to focus on African Americans in four communities to reduce low birth weight and infant mortality.

RPC 3 continued the lay health advisory training program, Community Voices, which is a MOD grant funded program to decrease African American infant deaths. Taking it to the People, a perinatal health curriculum developed by RPC 3 in response to a FIMR reccommendation , is for the layperson and covers basic perinatal health topics as well as psychosocial issues including domestic violence and substance abuse.

This state performance measure will not be continued. It was originally based on nine Healthy Start communities, which are no longer funded because their infant mortality ratio declined. A new state outcome measure will address disparities by monitoring the black/white LBW ratio for singletons.

State Performance Measure 14: *Percent of newborns screened for genetic diseases who receive recommended follow-up services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	62	87	103	114	
Denominator	62	87	103	114	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

State Performance Measure # 14 is the same as National Performance Measure # 1.

Notes - 2003

2003 data will not be available until later this year.

Notes - 2004

2004 data not available.

a. Last Year's Accomplishments

During FY 04, the Virginia Newborn Screening Services (VNSS) Program, supported by newborn screening testing revenue (Enterprise funds) through the Division of Consolidated Laboratories Services (DCLS) and Title V funds, screened all newborns for nine inborn errors

of body chemistry: (1) phenylketonuria (PKU), (2) maple syrup urine disease, (3) homocystinuria, (4) biotinidase deficiency, (5) galactosemia, (6) congenital hypothyroidism, (7) congenital adrenal hyperplasia, and (8) hemoglobinopathies. Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD) screening was implemented on March 1, 2004 following the addition of MS/MS instrumentation by DCLS. VNSS staff (two contract nurses) followed up on approximately 21,000 abnormal results and assured that confirmed cases were referred for treatment (see Form 6 for specific screening data). Enhancements were made to the DCLS and VNSS shared database, StarLIMS, to increase the efficiency of VNSS follow-up activities.

The Virginia Genetics Program (VGP) continued to support two metabolic treatment centers for children identified through VNSS at the Departments of Medical Genetics at the University of Virginia and at Virginia Commonwealth University. Eastern Virginia Medical School was added as the state's third metabolic treatment center to provide more proximal services for the Tidewater area of the Commonwealth. Under contractual agreements, these centers provide the following services: (1) 24/7 consultation for local health care providers to facilitate early diagnosis and treatment of infants identified as having abnormal results from newborn screening; (2) laboratory services to monitor blood levels and make recommendations for modification of diet and metabolic formula; (3) patient and family education related to specific disorders and their management; (4) coordination of necessary genetic testing for families to assist them in making informed decisions; and (5) provision of data and long-term case management information to the VGP. The VGP also administered the provision of special food products, including metabolic formulas, for the treatment of individuals with inborn errors of metabolism. The VGP is supported by Enterprise and Title V funding.

In response to a 2003 Virginia General Assembly mandate, the Joint Commission on Health Care conducted a study to explore expansion of the current newborn screening panel. This study recommended the current panel be expanded to include the the disorders consistent with, but not necessarily identical to, the uniform condition panel recommended by the HRSA-commissioned report, Newborn Screening: Toward a Uniform Screening Panel and System by the American College of Medical Genetics.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain screening of nine inborn errors of body chemistry-metabolic, endocrine, and hematologic.			X	
2. Monitor all newborn screening results and conduct aggressive follow-up on all abnormal results.			X	
3. Provide PKU formulas and other food products.	X			
4. Maintain the Virginia Infant Screening and Infant Tracking System (VISITS) birth defects database.				X
5. Maintain contracts with medical specialists statewide to provide metabolic treatment and consultation.	X			
6. Prepare for the expansion of newborn screening services to start March 1, 2006.			X	
7. Provide follow-up tracking for newborns identified with sickle cell disease through VASCAP.	X			
8.				
9.				

10.				

b. Current Activities

VNSS continues to screen all infants for nine inborn errors of body chemistry and track and follow-up all abnormal results. The VGP continues to administer the provision of special food products, including formulas, for the treatment of individuals with inborn errors of metabolism and oversee contractual services through the three metabolic treatment centers.

The 2005 Virginia General Assembly session introduced four bills recommending the expansion of the current panel of newborn screening disorders. Legislation mandating newborn screening expansion in Virginia by March 2006 consistent with the HRSA commissioned report and recommendations was passed and signed into law by the Governor. Additional funds for this expansion were designated in the state budget for VDH through increases in newborn screening testing fees. Emergency regulations are under development as specified in the new law to govern the program. VNSS is working with DCLS and the Virginia Genetics Advisory subcommittee on Newborn Screening to guide implementation planning. Current VNSS activities underway related to expansion implementation include hiring additional nursing and support staff for tracking, follow-up, and administrative functions anticipated with increased volume of abnormal screenings. Staff are also developing resource materials such as fact sheets, protocols, and healthcare provider training tools. VGP/VNSS will be participating in the HRSA-sponsored Mid-Atlantic Genetic and Newborn Screening Collaborative through the New York State Department of Health Wadsworth Laboratory.

In February 2005, the vacant Newborn Screening Nurse Senior position was filled with a permanent full time employee.

c. Plan for the Coming Year

VNSS will implement screening for an additional 17 disorders by March 1, 2006. Adding these disorders to the state-mandated panel will bring Virginia into compliance with recommendations from the HRSA commissioned report by the American College of Medical Genetics. Emergency regulations governing newborn screening in Virginia will be completed and implemented for the expansion start date. Concurrent work on making these regulations permanent will be conducted as well. Statewide training events and other training activities will occur to ready practitioners for the screening of the additional disorders.

VNSS will continue the following activities: (1) ensure screening of all infants for the mandated panel of inborn errors of body chemistry; (2) track and follow-up on all abnormal results and assure that confirmed cases are referred into treatment in a timely manner; (3) administer the provision of special food products for the treatment of individuals with inborn errors of metabolism; and (4) provide necessary education and technical assistance to providers. VNSS will continue work to enhance the follow-up and reporting functions of the StarLIMS database. These enhancement activities will occur in cooperation with the Division of Consolidated Laboratories (DCLS) under whose authority StarLIMS operates.

In addition, VGP will strengthen collaborative efforts with the Children with Special Health Care Needs (CSCHN) (VDH managed) and Early Intervention (Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) managed) programs to link children from the birth defects registry to needed resources. These include Care Connection for Children (CCC) -- a statewide network of regional programs that provide health care services, care coordination, community support and resources to children with special health care needs (including those with inborn errors of body chemistry), and early intervention services through the Infant & Toddler Connection of Virginia.

This state performance measure will not be included in future plans.

E. OTHER PROGRAM ACTIVITIES

The Virginia Department of Health, Early Childhood Health Program in collaboration with the Emergency Preparedness and Response Program developed It Pays to Prepare, an emergency preparedness guide for use by child care providers. It was paired with the First Aid Guide for School Emergencies to help child care providers manage emergencies. The guidelines and flip charts have been distributed to 20,000 child care providers throughout Virginia.

VDH received an Early Childhood Comprehensive Systems Planning Grant in FY 04. The environmental scan being conducted for this grant will be integrated with the upcoming Title V MCH Block Grant needs assessment. The Early Childhood Project director is serving as one of eleven policy fellows with the National Governors' Association and Zero to Three Early Childhood Policy Fellowship. This nurse consultant has continued to serve as the VDH representative on the Child Day Care Council, which promulgates minimum licensing requirements for licensed child care centers. In addition, the Early Childhood Project director served on the state School Readiness Indicators Team, a Ford Foundation project spearheaded under the direction of the Governor's Office. The task force was initiated in 2002 to identify the indicators and Virginia published the data source book in April 2004. Indicators focused on the child, family, and community as well as early childhood support services. Indicators included child health insurance, teen births, maternal education, low birth weight, and elevated lead levels. This group has continued to meet quarterly to track indicators and plans are underway to republish the source book comparing the initial indicators work with progress that has been achieved over the past few years. The work of the indicators groups is continuing by interfacing with the MCHB Early Childhood Comprehensive Systems grant. A final partnership is the Governor's Early Childhood Summit. The Summit is scheduled to be held May 23-26, 2005 and will focus on recognition of the importance of early childhood development. Organizations supporting and serving children ages 0-5 years will take part in this unique celebration by planning or participating in an event in their local community. The target audience includes parents, providers, community leaders, the corporate community, the media, and the legislature to receive education about the benefits of investing in early childhood.

Central Commonwealth Perinatal Council (RPC 6) worked on improving the health outcomes of very low birth weight infants by assuring resuscitation and stabilization of infants in the rural communities in this region. An NRP instructor's course was held at four hospitals. Providers were given updated Perinatal Continuing Education Program guidelines and a total of 34 participants and 1811.5 contact hours for this course. The council continued hospital neonatal transports reviews.

In FY 04, all seven RPCs trained 18,382 professionals in obstetrical (221), neonatal (253) and other programs (129) totaling 1406.31 program hours. Most were nurses (3,351) and respiratory therapists and consumers (13,276), while others were physicians (1,020), health educators (255), social workers (139), resource mothers (124), and nutritionists (48).

F. TECHNICAL ASSISTANCE

General Systems Capacity
1. Financial/Grant Monitoring Systems. Identify states with proven practices in Title V financial/grant monitoring systems. A Virginia team would make site visits to determine how the best practices may be included in an updated Virginia system. Virginia is considering improvements to the Title V financial/grant monitoring system and also has a number of new financial/grants administration staff that would benefit from other states experience.

2. One of Virginia's MCH priorities is to develop a holistic continuum of care model for women's health services across the life-span. Taking this approach focuses on girls health, women's preconceptual

health and ultimately leads to better birth outcomes as well as healthy older adult women. To begin Virginia would like to focus efforts on chronic diseases and the risk of chronic diseases identified during pregnancy. Both the chronic disease program and women's health program are located in the Office of Family Health Services. Consultation from another state that has successfully developed collaboration between/among chronic disease and MCH would be beneficial. Also Dr. Dawn Misra could provide consultation on efforts relating to the identification of chronic disease and risks for chronic disease during pregnancy.

Data-Related Issues

1. Data Linking. Seek Assistance from a state that has successfully linked data such as birth records, death records and Medicaid files to provide guidance to Virginia's efforts. Examples of the consultant state's assistance could include lessons learned and examples of how the linked data is currently used. (This also supports Virginia's SSDI efforts)

V. BUDGET NARRATIVE

A. EXPENDITURES

Form 4 lists expenses for FY 2004 by the types of individuals served. There is a variance of approximately 2.6% or $48,816 for the pregnant women served from the budgeted amount of $1,865,900 to $1,914,716 expended. The expended amount is based on the actual visits while the budgeted amount is an estimate based on the prior years visits. The amount expended for infants also increased in FY2004 due to the increased funding to support screening activities and visits. Form 5 shows that Direct Health Care has a variance from the budgeted amount. This reflects a continuing decrease in the provision of direct clinical services in the district health departments. In FY 04 added emphasis is being placed on health education and translation services geared toward pregnant women, infants and children. Therefore, the expenditures in the Other category on Form 4 and Population-Based Services on Form 5 reflects this shift in emphasis

B. BUDGET

The Federal-State Title V block grant partnership budget provides funds for maternal and child health services, primary care for children and adolescents, preventive and maintenance services to children with special health care needs.

Preventive and primary care services for pregnant women and mothers include the following:

Policy and procedural oversight concerning women's services
Nutrition services for women
Contracts to local health departments for maternal health services
Pharmacy and laboratory testing for pregnant women
Regional Perinatal Coordinating Council to include professional outreach education
Fetal Infant Mortality Review (FIMR)

Prevention and primary care services for infants services include:

Policy and procedural oversight concerning infant services
Contracts to local health departments for infant health services
Regional Perinatal Coordinating Council to include professional outreach education
Newborn screening and follow up

Funds for prevention and primary care services for children and adolescents include activities aimed at reducing the incidence of health problems and the prevalence of community and risk factors for these problems. Services also include the promotion of health and the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, and the overall management responsibility of secondary and tertiary care. Other specific services include:

Policy and procedural oversight concerning child and adolescent program development
Nutrition services
Child and adolescent health programs including injury prevention, lead poisoning prevention, Child Care Nurse Consultant Services, Medical Home/Access to Care initiatives
Resource Mothers Program, primary care initiatives, and school health
Family planning services for patients under age 22 and teen pregnancy prevention
Maternal health services for patients under age 22
Laboratory testing and pharmacy services, sickle cell services
Dental health education and assessment

Funds dedicated to serve population include the following services:

Policy and procedural oversight concerning women's services

Contracts to local health departments for family planning services
Laboratory testing and pharmacy services

Services for children with special health care needs include family-centered, community-based coordinated care for persons from birth through age 20 who have or are at risk for disabilities, handicapping conditions, chronic illnesses and conditions or health related educational or behavioral problems. Services also include the development of community-based systems of care for such children and their families. Examples are:

Specialized medical-surgical care programs
Care coordination
Interdisciplinary diagnostic evaluations
Follow-up services
Inpatient hospitalization
Outpatient surgery
Pharmacy services
X-ray and laboratory services
Supplies and equipment
Genetic testing, counseling and education
Nutrition services

Agency administrative costs are incurred by the Virginia Department of Health in the administration of federal and other grants by individuals other than those employed for the sole purpose of support for the grant. As in previous applications, the FY05 budget does not include funds for administrative costs. The definition of administrative costs adopted by the Virginia Department of Health relative to the Title V Block Grant includes the following cost components:

a. Overall agency management and policy direction for the Title V Block Grant.
b. Agency provision of accounting, budgeting, payroll, financial control, and financial reporting services as required for the grant by individuals other than those employed for the sole purpose of support for the grant.
c. Personnel services, including classification and compensation management, grievance handling, recruitment and referral of applicants, program monitoring for equal employments opportunity, standards of conduct and employee performance evaluation.
d. Support services for the provision of essential supplies, equipment, mail materials and technical assistance.

As required by Section 505 of Title V, the state will budget at least 30% of the total federal allocation for preventive and primary care services for children. Also, at least 30% of the total federal allocation for family-centered, community-based, coordinated care for children with special health care needs, and the development of community-based systems of care for such children and their families. As shown in Budget Form 2, $4,032,822 or approximately 31.16% of the total budgeted federal funds of $12,942,168 will be used for preventive and primary care services for children (including infants) and adolescents; $5,451,878 or approximately 42.12% of the total will be used for children with special health car needs. The remaining 26.72% of the total budgeted federal funds or $3,457,468 will be used for preventive and primary care services for pregnant women, mothers, and non-pregnant women over 21 years.

The funds provided by the state for FY06 for maternal and child health services are at a level that exceeds the fiscal year 1989 level. During the period of October 1988 through September 30, 1989, $8,718,003 in state funds for Title V maternal child health services was expended; this compares to the fiscal year 2006 allocation of $11,598,037 in state funds for these services. During federal fiscal year 1989, a total of $9,033,260 in federal fund was expended and the Commonwealth of Virginia overmatched the 4:3 requirement by $1,943,058.

The amount of state funds expended in fiscal year 1989 was determined by including all state funds

used for the Title V match and overmatch for all Title V-funded units, and for the childhood immunization program. The state has an established fiscal management system to ensure a clear audit trail. A specific program coding numbers is assigned to each program, which is not duplicated. The program director or designee reviews all requests for payments. All new financial new financial systems used by the Department of Health are reviewed by internal and state auditors prior to implementation and receive the approval of State Auditor's Office. The State Auditor's Office audits all federal programs yearly and its report is forwarded to federal program officials.
Title V funds are used to carry out the purposes of this title and the following activities previously conducted under the Consolidated Health Programs:
a. Lead poisoning prevention: The program currently receives funds through a CDC State and Community-Based Childhood Lead Poisoning Prevention Programs grant and an EPA grant. Title V funds are used to provide programmatic direction to this program.
b. Genetics: The three original programs located at the University of Virginia, Virginia Commonwealth University, and the Eastern Virginia Medical School and a fourth genetics center, the Fairfax Genetics and IVF Institute, currently receive funds. Projected funding for FY2006 is $828,725.
c. Virginia did not receive Sudden Infant Death Syndrome (SIDS) funds; however, the Division of Women's and Infants' Health does provide information to families of SIDS infants.

Based on the State's previous use of funds under this title, a reasonable proportion of the allotted funds will be used to carry out the purposes of the Act described in Section 501(a)(1)(A) through (D).

Title V funds ($7,490,289) will be used for preventive and primary care services for pregnant women, non-pregnant women of child bearing age, mothers, infants, children and adolescents. These funds will be used for the following services: family planning services, local health department prenatal and child health services, genetic testing/counseling/pharmacy and education, Regional Perinatal Coordinating Councils including professional outreach education, primary care initiatives, injury prevention, lead poisoning prevention, and local programs to reduce infant mortality including the Resource Mothers Program and the Nutrition Intervention Project for Underweight Pregnant Women. These services serve the purposes outlines in Section 501(a)(1)(A) and (B).

Title V funds ($5,451,878) will be used to provide and promote family-centered community-based, coordinated care for children with special health care needs and the development of community-based systems of care for such children and their families. These services include specialized diagnostic, treatment; care coordination and follow-up services provided by children's specialty clinics and child development clinics. These services meet the purposes described in Section (a)(1)(C) and (D).

The general funds targeted to support the match requirement are estimated at $11,598,037. These dollars dedicated as match for Title V exceed the 4:3 requirement by $1,847,202. Program income is estimated at $2,032,672. The total budget, including projected match Title V funds, and program income is estimated to be $26,572,877.

Along with $26,572,877 in Title V federal and state funds designated Form 2, additional Federal funds are provided for maternal and child health services in Virginia. In FY 2006, CDC funds include Title X, $4.5 million; Lead Poisoning Prevention for $580,810; Unintentional and Targeted Injury Prevention for $378,050, and other CDC programs totaling $4,324,220. Other anticipated sources of MCH targeted funding include dollars for the Women, Infants, and Children (WIC) nutrition program. The actual amount of FY06 is unknown at this time; however, funding is estimated to be $72 million. Additionally, estimated funds dedicated for Healthy Start are $1 million; SSDI, $100,000; CISS, $100,000; and, Abstinence Education, $859,320.

In FY 2006, $8,664,400 in "other" federal funding includes: Department of Medical Assistance Services (DMAS) for the Resource Mothers Program($447,500). The Department of Social Services provides Temporary Assistance to Needy Families (TANF) funding totaling $1.9 million, which includes funding for Teen Pregnancy Prevention Initiative and Partners in Prevention; Maternal and Child Health Bureau (MCHB) additional grant funds include Universal Hearing Screening and the

Increasing Insurance for CSHCN totaling $1,163,204; EPA for lead poisoning prevention initiatives, $538,180. Also, $43.9 million in state and local funds and revenues are budgeted for statewide maternal and child health services, including family planning and dental health services.

There are no known un-obligated balances for the state fiscal year ending June 30, 2005 that are budgeted for the next state fiscal year 2006. Once the final balances are known, Virginia will provide a budget revision and identify the additional initiatives that will be funded with the balances. The revision will identify initiatives and ensure the 30-30 requirement is met.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.